

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film G254 1-11-60 et

Reg. Dist. No.

00796

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>0857</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kkk D.C.</u> b. COUNTY <u>Wkllt</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
c. LENGTH OF STAY IN lb <u>8 yrs</u>		d. STREET ADDRESS <u>2100 Connecticut Ave. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth F. Alterman</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-29-1903</u>
9. AGE (In years last birthday) <u>56 yrs.</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (State or foreign country) <u>DC.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry Fowler</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Horwitz</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>		17. INFORMANT <u>Elizabeth Horwitz, daughter-New York</u> Address <u>Kensington Gardens Nursing Home Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331x</u> DUE TO (c) <u>331x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Distal Myeloma (years)</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1/6/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JAN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate containing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>Male</u>	
3. AGE <u>45</u>		4. RACE <u>White</u>	
5. DATE OF DEATH <u>10/15/1968</u>		6. TIME OF DEATH <u>10:30 AM</u>	
7. PLACE OF DEATH <u>Home</u>		8. STREET <u>1234 Main St</u>	
9. CITY <u>Baltimore</u>		10. COUNTY <u>Harford</u>	
11. STATE <u>Md</u>		12. ZIP CODE <u>21040</u>	
13. OCCUPATION <u>Engineer</u>			
14. MARITAL STATUS <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
15. NAME OF SPOUSE <u>John J. Smith</u>			
16. NAME OF CHILDREN <u>John J. Smith Jr.</u>			
17. NAME OF NEXT OF KIN <u>John J. Smith Jr.</u>			
18. NAME OF PHYSICIAN <u>John J. Smith Jr.</u>			
19. NAME OF HOSPITAL <u>John J. Smith Jr.</u>			
20. NAME OF NURSING HOME <u>John J. Smith Jr.</u>			
21. NAME OF FUNERAL HOME <u>John J. Smith Jr.</u>			
22. NAME OF BURIAL PLACE <u>John J. Smith Jr.</u>			
23. NAME OF CEMETERY <u>John J. Smith Jr.</u>			
24. NAME OF INTERMENT <u>John J. Smith Jr.</u>			
25. NAME OF CREMATION <u>John J. Smith Jr.</u>			
26. NAME OF URN <u>John J. Smith Jr.</u>			
27. NAME OF CASK <u>John J. Smith Jr.</u>			
28. NAME OF COFFIN <u>John J. Smith Jr.</u>			
29. NAME OF CASKET <u>John J. Smith Jr.</u>			
30. NAME OF CASKET <u>John J. Smith Jr.</u>			
31. NAME OF CASKET <u>John J. Smith Jr.</u>			
32. NAME OF CASKET <u>John J. Smith Jr.</u>			
33. NAME OF CASKET <u>John J. Smith Jr.</u>			
34. NAME OF CASKET <u>John J. Smith Jr.</u>			
35. NAME OF CASKET <u>John J. Smith Jr.</u>			
36. NAME OF CASKET <u>John J. Smith Jr.</u>			
37. NAME OF CASKET <u>John J. Smith Jr.</u>			
38. NAME OF CASKET <u>John J. Smith Jr.</u>			
39. NAME OF CASKET <u>John J. Smith Jr.</u>			
40. NAME OF CASKET <u>John J. Smith Jr.</u>			
41. NAME OF CASKET <u>John J. Smith Jr.</u>			
42. NAME OF CASKET <u>John J. Smith Jr.</u>			
43. NAME OF CASKET <u>John J. Smith Jr.</u>			
44. NAME OF CASKET <u>John J. Smith Jr.</u>			
45. NAME OF CASKET <u>John J. Smith Jr.</u>			
46. NAME OF CASKET <u>John J. Smith Jr.</u>			
47. NAME OF CASKET <u>John J. Smith Jr.</u>			
48. NAME OF CASKET <u>John J. Smith Jr.</u>			
49. NAME OF CASKET <u>John J. Smith Jr.</u>			
50. NAME OF CASKET <u>John J. Smith Jr.</u>			

0797

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>4 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>310 Timberwood Avenue</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b> d. STREET ADDRESS <b>310 Timberwood Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>EVERETT</b> Last <b>ATKISSON</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1916</b>
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Part owner &amp; mgr. Brooke Manor Country Club</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Missouri</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT B. ATKISSON</b>		14. MOTHER'S MAIDEN NAME <b>ERMAL T. RUSSELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW # 2 577-40-2688</b>	
17. INFORMANT <b>Mrs. Dorothy E. Atkisson, 310 Timberwood Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential Hypertension</b> DUE TO (c) <b>Coronary Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day 3 years 3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1, 1957</b> to <b>Jan 5, 1960</b> that I last saw the deceased alive on <b>Jan 5, 1960</b> , and that death occurred at <b>11:56 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10620 Georgia Ave Silver Spring, Md</b> DATE SIGNED <b>1/5/60</b>			
ACTUAL SIGNATURE <b>John J. Curry</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/8/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>NAT'L. MEM. PARK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>FALLS CHURCH, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Judd</b>		24a. REC'D BY REGISTRAR <b>JAN 8 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00798

0798

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8405 Flower Ave.</b>		d. STREET ADDRESS <b>18405 Flower Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Albert Russell</b> First Middle Last		4. DATE OF DEATH <b>JANUARY 8 1960</b> Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 11, 1878</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Letter Carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USPOST office</b>	
11. BIRTHPLACE (State or foreign country) <b>Altoona, Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry J. Aukerman</b>		14. MOTHER'S MAIDEN NAME <b>Beth Elizabeth Aukerman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Wife: Mrs. Beth Aukerman</b> Address <b>same address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute Pulmonary Edema</b> <b>420.0</b> DUE TO <b>Severe Chronic Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Artherosclerotic Heart Disease</b> (c) <b>2+ years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Asystole + urtemia, generalized atherosclerosis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 1957</b> , to <b>8 Jan. 1960</b> , that I last saw the deceased alive on <b>7 January, 1960</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9804 Dilston Road</b> DATE SIGNED <b>1-8-60</b> ACTUAL SIGNATURE <b>Fredrick Barr MD</b> PHYSICIAN'S NAME (Type) <b>J. Frederick BARR Silver Spring, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/11/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GEO. WASH. MEM. CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. BUMPNEY INC.</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>JAN 12 1960</b> DATE	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

CERTIFICATE OF DEATH

See Form No. 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Minister		7. MARITAL STATUS Single		8. COLOR White		9. HIGHEST SCHOOLING High School		10. RELIGION Methodist	
11. DATE OF DEATH April 4, 1968		12. TIME OF DEATH 2:01 PM		13. PLACE OF DEATH Memphis, Tennessee		14. CAUSE OF DEATH Gunshot wound		15. MANNER OF DEATH Suicide	
16. SIGNATURE OF PHYSICIAN [Signature]		17. SIGNATURE OF MINISTER [Signature]		18. SIGNATURE OF CORONER [Signature]		19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF WITNESSES [Signatures]	
21. I hereby certify that the deceased died of the disease or injury stated on this certificate and that the cause of death is as stated.		22. I hereby certify that the deceased died of the disease or injury stated on this certificate and that the cause of death is as stated.		23. I hereby certify that the deceased died of the disease or injury stated on this certificate and that the cause of death is as stated.		24. I hereby certify that the deceased died of the disease or injury stated on this certificate and that the cause of death is as stated.		25. I hereby certify that the deceased died of the disease or injury stated on this certificate and that the cause of death is as stated.	

## CERTIFICATE OF DEATH

Reg. Dist. No.

00799

0820

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CEDAR HAVEN REST HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CECELIA</b> Middle <b>JOSEPHINE</b> Last <b>AUSMEYER</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>25</b> Year <b>19 60</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/19/89</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min.		IF UNDER 24 HRS. Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Mrs. Dolores G. Palmer, 8904 Colesville Rd. Silver Spring, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bleeding Peptic Ulcer &amp; Heart Failure</b> DUE TO (c) <b>Arteriosclerosis &amp; Hypertension</b> INTERVAL BETWEEN ONSET AND DEATH <b>24hrs</b> <b>7d</b> <b>Indef</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Adenocarcinoma, ovarian, metastatic</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12/29</b> , 19 <b>59</b> , to <b>1/25</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/25/60</b> , 19 <b>60</b> , and that death occurred at <b>11:20</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. L. MARSTON</b>				ADDRESS (Street, city or town, state) <b>800 Pershing Drive Silver Spring Md</b>			
PHYSICIAN'S NAME (Type) <b>E. L. MARSTON</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/28/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>JAN 27 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kenna</b>							

TO HOSPITAL OR A MORGUE: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAINTENANCE OF ORDER - 07-08-2019

• • •

0799

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>22 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>none 8904 Colesville Rd.</b>				e. STREET ADDRESS <b>8904 Colesville Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> C Middle <b>AUSMEYER</b> Last				4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/6/89</b>	
9. AGE (In years lost birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done) <b>retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>DEPT. OF DEFENSE</b>		11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>MRS. CECILIA J. AUSMEYER</b>				Address <b>8904 Colesville Rd. Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>coronary arteriosclerosis</b> DUE TO (c) <b>indef.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no injury</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>8:45 a.m. 1/13/60</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	
20f. (City or town) <b>-----</b>				20g. (County) <b>-----</b>		20h. (State) <b>-----</b>	
21. I certify that I attended the deceased from <b>1/13/60</b> , 19____, to <b>1/13/60</b> , 19____, that I last saw the deceased alive on <b>1/13/60</b> , 19____, and that death occurred at <b>8:45 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E.L. Marston</b>				ADDRESS (Street, city or town, state) <b>800 Pershing Drive Silver Spring, Md.</b>			
PHYSICIAN'S NAME (Type) <b>E.L. Marston, M.D.</b>				DATE SIGNED <b>E.L. Marston, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond H. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 15 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0599

MINISTERS STATE DEPARTMENT OF HEALTH, BALTIMORE, MD.

County of Baltimore, Maryland  
Silver Spring, Maryland  
John J. Silver Spring, Maryland  
1000 Colverville Road, Silver Spring, Maryland

Age 45 years  
Male  
Single  
Occupation: Engineer  
Cause of Death: Myocardial Infarction  
Date of Death: January 13, 1960

Signature of Physician: [Signature]  
Signature of Registrar: [Signature]  
Signature of Informant: [Signature]

Time of Death: 1:15 PM  
Date of Death: January 13, 1960  
Place of Death: Home

Informant: [Name]  
Address: [Address]  
Signature: [Signature]  
Date: [Date]



0879

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norbeck</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Phelomenas Nursing Home</u>				d. STREET ADDRESS <u>430 Longfellow St NW</u>			
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>E</u> Last <u>BAILEY</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 20, 1879</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Altman</u>		11. BIRTHPLACE (State or foreign country) <u>Woodsboro, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
3. FATHER'S NAME <u>Negemiah Fay</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Bronchopneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>10 years</u> <u>2 wks.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1, 1959</u> to <u>Jan 30, 1960</u> , that I last saw the deceased alive on <u>Jan 22, 1960</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry J. Kuehn</u> M.D.				ADDRESS (Street, city or town, state) <u>5527 Surrey St.</u>			
DATE SIGNED <u>  </u>							
PHYSICIAN'S NAME (Type) <u>Cherry Chase, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Feb. 2, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St NW DC</u>				24. REC'D BY REGISTRAR <u>FEB 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



*[Faint, illegible text, likely bleed-through from the reverse side of the page.]*

## CERTIFICATE OF DEATH

Reg. Dist. No.

00802

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>7801-12th St. NW.</u>			
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>(no)</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>WT.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-22-95</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u> Hours <u>1</u> Min. <u>1960</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>2</u> Hours <u>1</u> Min. <u>1960</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Demonstrator of Cosmetics</u>			
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Henry Baker</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Wholers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Hospital Records</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Carcinoma</u> <u>170x</u> DUE TO <u>of right breast with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis</u> DUE TO <u>metastasis</u> (c) <u>metastasis</u> INTERVAL BETWEEN ONSET AND DEATH <u>(?) 9 months or more</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>170x</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 4</u> , 1960, to <u>Jan 7</u> , 1960, that I last saw the deceased alive on <u>Jan 6</u> , 1960, and that death occurred at <u>12:45 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive</u>				DATE SIGNED <u>1-7-60</u>			
ACTUAL SIGNATURE <u>Philip C. Jones</u>				M.D. <u>Silver Spring Md.</u>			
PHYSICIAN'S NAME (Type) <u>Philip E Jones</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Hines Co</u>				ADDRESS <u>2901-14th St. N.W.</u>			
24a. REC'D BY REGISTRAR <u>JAN 8 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. DATE OF DEATH		12. TIME OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF CORONER		25. SIGNATURE OF JURY	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESSES		28. SIGNATURE OF PHYSICIAN		29. SIGNATURE OF CORONER		30. SIGNATURE OF JURY	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESSES		33. SIGNATURE OF PHYSICIAN		34. SIGNATURE OF CORONER		35. SIGNATURE OF JURY	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF WITNESSES		38. SIGNATURE OF PHYSICIAN		39. SIGNATURE OF CORONER		40. SIGNATURE OF JURY	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESSES		43. SIGNATURE OF PHYSICIAN		44. SIGNATURE OF CORONER		45. SIGNATURE OF JURY	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESSES		48. SIGNATURE OF PHYSICIAN		49. SIGNATURE OF CORONER		50. SIGNATURE OF JURY	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF WITNESSES		53. SIGNATURE OF PHYSICIAN		54. SIGNATURE OF CORONER		55. SIGNATURE OF JURY	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF WITNESSES		58. SIGNATURE OF PHYSICIAN		59. SIGNATURE OF CORONER		60. SIGNATURE OF JURY	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESSES		63. SIGNATURE OF PHYSICIAN		64. SIGNATURE OF CORONER		65. SIGNATURE OF JURY	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF WITNESSES		68. SIGNATURE OF PHYSICIAN		69. SIGNATURE OF CORONER		70. SIGNATURE OF JURY	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF WITNESSES		73. SIGNATURE OF PHYSICIAN		74. SIGNATURE OF CORONER		75. SIGNATURE OF JURY	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF WITNESSES		78. SIGNATURE OF PHYSICIAN		79. SIGNATURE OF CORONER		80. SIGNATURE OF JURY	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESSES		83. SIGNATURE OF PHYSICIAN		84. SIGNATURE OF CORONER		85. SIGNATURE OF JURY	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF WITNESSES		88. SIGNATURE OF PHYSICIAN		89. SIGNATURE OF CORONER		90. SIGNATURE OF JURY	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESSES		93. SIGNATURE OF PHYSICIAN		94. SIGNATURE OF CORONER		95. SIGNATURE OF JURY	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF WITNESSES		98. SIGNATURE OF PHYSICIAN		99. SIGNATURE OF CORONER		100. SIGNATURE OF JURY	

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West Hyattsville</i>	
c. LENGTH OF STAY IN 1b <i>2 days</i>		16-58-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp.</i>		d. STREET ADDRESS <i>6811 Riggs Manor Dr.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>Walter</i> Last <i>Bakersmith</i>		4. DATE OF DEATH Month <i>1</i> Day <i>9</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-27-21</i>
9. AGE (In years lost birthday) <i>38</i> yrs.		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gov't. Clerk - Gen. Acct. office</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John J. Bakersmith</i>		14. MOTHER'S MAIDEN NAME <i>Mary M. Barry</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>none</i>		16. SOCIAL SECURITY NO. <i>579-30-1624</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma - Lung, advanced &amp; metastatic</i> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June</i> , 19 <i>56</i> , to <i>January</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Jan 9</i> , 19 <i>60</i> , and that death occurred at <i>4:50</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wayne Clickfield</i> M.D.		ADDRESS (Street, city or town, state) <i>6826 Riggs Rd.</i>	
PHYSICIAN'S NAME (Type) <i>WAYNE CLICKFIELD M.D.</i>		<i>Hyattsville Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>1/12/1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Halley's Funeral Home</i>		ADDRESS <i>Mt. Rainier Md.</i>	
24a. REC'D BY REGISTRAR <i>JAN 13 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0885

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
BOSTON, MASS.  
JANUARY 1, 1900  
I hereby certify that on the 1st day of January, 1900, at the City of Boston, in the County of Suffolk, the following named person died:  
Name of deceased: John J. Anderson  
Age: 55 years  
Sex: Male  
Color: White  
Cause of death: Heart disease  
Place of death: Home  
Signature of Registrar: [Signature]  
Signature of Medical Officer: [Signature]

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
BOSTON, MASS.  
JANUARY 1, 1900  
I hereby certify that on the 1st day of January, 1900, at the City of Boston, in the County of Suffolk, the following named person died:  
Name of deceased: John J. Anderson  
Age: 55 years  
Sex: Male  
Color: White  
Cause of death: Heart disease  
Place of death: Home  
Signature of Registrar: [Signature]  
Signature of Medical Officer: [Signature]



## 0880 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington D.C.</b> b. COUNTY <b>Washington D.C.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN 1b <b>152 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b> <b>47X-3</b>		
f. STREET ADDRESS <b>1707 Surrey Lane N.W.</b>			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Lucile</b> Middle <b>Herold</b> Last <b>BARBARO</b>			4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-22-05</b>		9. AGE (In years last birthday) <b>54</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Edward E. Herold</b>		
14. MOTHER'S MAIDEN NAME <b>Lucile Allen</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>- -</b>		
16. SOCIAL SECURITY NO. <b>- -</b>			17. INFORMANT <b>Hospital Records</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO <b>153.8</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Colon</b> DUE TO (c) <b>2 yrs</b>					INTERVAL BETWEEN ONSET AND DEATH <b>8 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 21st 1959</b> , to <b>January 19th 1960</b> , that I last saw the deceased alive on <b>January 19th 1960</b> , and that death occurred at <b>1105 PM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>C. W. Bramlett</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital</b>		DATE SIGNED <b>1-20-60</b>	
PHYSICIAN'S NAME (Type) <b>C.W. BRAMLETT LT MC USN</b>		<b>Bethesda, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-22-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Gawler's &amp; Sons Funeral Home, 1756 Pa. Ave. NW</b>		ADDRESS <b>Wash. DC</b>		24a. REC'D BY REGISTRAR <b>JAN 22 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

1  
8

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

# CERTIFICATE OF DEATH

0883

Washington D.C.

Washington D.C.

1000 Twenty Lane N.W.

Age

1-22-02

Female

Female

Washington

Female

Washington

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Washington

Female

Female

Female

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Washington

January 1900

January 1900

1-22-02

Washington

Washington

Washington

Washington

Washington

Washington

1-22-02

Female

Female

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00805

FOR STATE  
HEALTH DEPT.

08-0

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Monty</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |  | c. LENGTH OF STAY IN 1b <u>1 yr</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8707 Reading Rd.</u>   |  | d. STREET ADDRESS <u>18707 Reading Rd</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Earl</u> <sup>first</sup> <u>Berkley</u> <sup>Middle</sup> <sup>Last</sup>  |  | 4. DATE OF DEATH <u>Jan</u> <sup>Month</sup> <u>29</u> <sup>Day</sup> <u>1960</u> <sup>Year</sup>  |  |
| 5. SEX <u>male</u>   | 6. COLOR OR RACE <u>white</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>1-3-1900</u>   |
| 9. AGE (in years last birthday) <u>60</u> yrs.   |  | 10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>  | 11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>                              |
| 10a. USUAL OCCUPATION (Give kind of work done) <u>World Service Editor</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>ASSOCIATED PRESS</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>ROME, OHIO</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>   |  |
| 13. FATHER'S NAME <u>LEONARD BERKLEY</u>   |  | 14. MOTHER'S MAIDEN NAME <u>MARY A. DeVoss</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |  | 16. SOCIAL SECURITY NO. <u>275-01-3852</u>   |  |
| 17. INFORMANT <u>Mrs. Mary C. Berkley, 8707 Reading Rd.</u>  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>  </u><br>(a), stating the underlying cause last. (c) <u>  </u> |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschalt</u> M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschalt</u>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | DATE SIGNED <u>1-29-60</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  | 22b. DATE THEREOF <u>2/1/60</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>  | 22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>   |  | 24a. REC'D BY REGISTRAR <u>  </u>  |  |
| ADDRESS <u>Silver Spring, MD.</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>  </u>   |  |



## 0801 CERTIFICATE OF DEATH

Reg. Dist. No.

00806

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b><br>c. LENGTH OF STAY IN 1b <b>Since March 9 1952</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>201 E. WAYNE AVENUE</b> |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b><br>d. STREET ADDRESS <b>1 201 E. WAYNE AVENUE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EDWIN</b> Middle <b>SHIPLEY</b> Last <b>BILLHIMER, SR.</b>  |                               | 4. DATE OF DEATH<br>Month <b>JAN.</b> Day <b>14</b> Year <b>19 60</b>  |  |
| 5. SEX <b>MALE</b>  | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>12/26/84</b>   |
| 9. AGE (In years last birthday) <b>75</b> yrs.  |                               | 10. IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.  | 11. IF UNDER 24 HRS.<br>Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Dealer (retired)</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>WILLIAM HENRY BILLHIMER</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>KATHERINE BOMAN</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <b>578-01-5202</b>   |  |
| 17. INFORMANT Address <b>Mrs. Genevieve L. Billhimer, 201 E. Wayne Ave. Silver Spring, Md.</b>  |                               | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>450.1</b> DUE TO <b>ARTERIO SCLEROSIS, GEN.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>10 yrs.</b><br>(c) <b>10 yrs.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PROSTATISM</b>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Apr. 1954</b> to <b>JAN. 1960</b> , that I last saw the deceased alive on <b>14 JAN. 1960</b> , and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.  |                               |  |  |
| ACTUAL SIGNATURE <b>Lee B. Snow</b>   |                               | DATE SIGNED <b>1/15/60</b>   |  |
| PHYSICIAN'S NAME (Type) <b>LEE B. SNOW</b>  |                               | ADDRESS (Street, city or town, state) <b>7950 NEW HAMPSHIRE AVE. LAUGLEY PARK, MD.</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                               | 22b. DATE THEREOF <b>1/16/60</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC. Raymond L. Ziska</b>   |                               | ADDRESS <b>SILVER SPRING, MD.</b>  |  |
| 24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>  |  |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0001 CERTIFICATE OF DEATH

Place of Birth

Date of Birth

Place of Death

Date of Death

Place of Burial

Date of Burial

Place of Interment

Date of Interment

Place of Cremation

Date of Cremation

Place of Disposition

Date of Disposition

Place of Disposition

Date of Disposition

Place of Disposition

Date of Disposition

Place of Disposition

Date of Disposition

Place of Disposition

Date of Disposition



## 0802 CERTIFICATE OF DEATH

Reg. Dist. No. 00807

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <del>MD.</del> MD. b. COUNTY <b>MONTGOMERY</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><del>56</del> <b>SILVER SPRING</b>                                      |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>8002 Newell Court</b>  |                                  | d. STREET ADDRESS <b>8002 NEWELL COURT</b><br><del>XXXXX - XXXXX XXXX XXXX</del>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ira</b> Middle <b>Webster</b> Last <b>Billner</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>25</b> Year <b>1960</b>  |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 7, 1886</b> |
| 9. AGE (In years lost birthday)<br><b>73</b> yrs.   |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>mechanic</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>AUTO</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Penn.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>Samuel S. Billner</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>HENRIETTA COLEMAN</b><br><del>XXXXX XXXXX XXXX</del>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>59748416</b>  |  |
| 17. INFORMANT<br><b>Bone: Kland Billner</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) <b>with Infarction</b><br>lying cause lost. (c) |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. p. m. 19  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>10/27/52</b> , 19____, to <b>Jan 25, 1960</b> , that I last saw the deceased alive on <b>Jan 24</b> , 19 <b>60</b> , and that death occurred at <b>7:05 PM</b> , from the causes and on the date stated above.   |                                  |   |  |
| ACTUAL SIGNATURE <b>Philip E. Jones</b> M.D.  |                                  | ADDRESS (Street, city or town, state) <b>918 Ellsworth Drive</b> DATE SIGNED <b>1-25-60</b>   |  |
| PHYSICIAN'S NAME (Type) <b>Philip E. Jones</b>  |                                  | <b>Silver Spring, Md.</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>1/28/60</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>GLENWOOD CEMETERY</b>  |                                  | 22d. LOCATION (City, town, or County) (State)<br><b>WASHINGTON, D.C.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PUMPHREY, INC.</b><br><b>Raymond A. Hake</b>   |                                  | ADDRESS<br><b>SILVER SPRING, MD.</b>  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 27 '60</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kneass</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1954

0853

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <i>Montg</i><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>Md</i><br>b. COUNTY <i>Montg</i>                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Gaithersburg</i>   |   | c. LENGTH OF STAY IN lb<br><i>10/11/60 -</i>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>REVA</i> Middle <i>Billings</i> Last <i>BOEKHOFF</i>  |   | 4. DATE OF DEATH<br>Month <i>JANUARY</i> Day <i>13</i> Year <i>1960</i>  |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>July 15 - 1887</i>  |
| 9. AGE (In years last birthday)<br><i>72 yrs.</i>   |   | 10. IF UNDER 1 YEAR<br>Months <i>5</i> Days <i>28</i>  | 11. IF UNDER 24 HRS.<br>Hours <i></i> Min. <i></i>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i></i>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>New York (State)</i>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA.</i>  |  |
| 13. FATHER'S NAME<br><i>Unknown</i>   |   | 14. MOTHER'S MAIDEN NAME<br><i>Unknown</i>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service   |   | 16. SOCIAL SECURITY NO.<br><i></i>   |  |
| 17. INFORMANT<br><i>Cecil Carter</i>  |   | Address<br><i>Gaithersburg Md</i>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>CORONARY OCCLUSION</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Arteriosclerotic Heart disease</i><br>(c) <i>arteriosclerosis</i>  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>INSTANTANEOUS</i><br><i>2 years</i><br><i>2 years</i>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><i>mild Diabetes mellitus</i>   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><i></i>  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <i></i> p. m. <i></i><br>19 <i></i>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><i></i>  | 20f. (City or town) (County) (State)<br><i></i>  |
| 21. I certify that I attended the deceased from <i>January</i> , 19 <i>48</i> , to <i>Jan. 13</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Jan. 7</i> , 19 <i>60</i> , and that death occurred at <i>9:30 A.M.</i> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><i>Dawsonville</i><br>ACTUAL SIGNATURE <i>John G. Fawcett</i> M.D. <i>P.O. Boyal Md.</i><br>PHYSICIAN'S NAME (Type) <i>JOHN G. FAWCETT.</i> |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Cremation</i>   | 22b. DATE THEREOF<br><i>1-16-60</i>   | 22c. NAME OF CEMETERY OR CREMATORY<br><i>St Lincoln</i>  | 22d. LOCATION (City, town, or county) (State)<br><i>Bladensburg Md</i>                         |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Arthur S. Kram</i>   |   | 24a. REC'D BY REGISTRAR<br>DATE <i>JAN 18 '60</i>  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kram</i>  |

TO HOSPITAL: A copy of this certificate must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1000

## CERTIFICATE OF DEATH

Reg. Dist. No.

00809

0881

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MARYLAND</b><br><b>Montgomery</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Virginia</b><br>b. COUNTY <b>Prince George</b>         |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>73 days</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| d. STREET ADDRESS<br><b>403 Allen Avenue</b>   |  |   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>William</b>  |  | First<br><b>Lee</b>                       |  | Last<br><b>Booth</b>  |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>28</b> Year <b>1960</b> |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>January 28, 1904</b>                             |  |
| 9. AGE (In years lost birthday)<br><b>56</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cook</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Benjamin Booth</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Cora Vaughn</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>120-10-2169</b>   |  |   |  |
| 17. INFORMANT<br><b>The Medical Record</b>   |  |   |  | Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic coma with irreversible shock</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Hepatic metastasis</b><br>DUE TO<br>(c) <b>Bronchogenic carcinoma</b> |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>2 weeks</b><br><b>8 months</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>                          |  | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)   |  |   |  |   |  |   |  |
| 21. I certify that I attended the deceased from <b>November 16, 1959</b> , to <b>January 28, 1960</b> , that I last saw the deceased alive on <b>January 28, 1960</b> , and that death occurred at <b>8:25 AM</b> , from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Gordon C. Sharp</b>  |  |   |  | ADDRESS (Street, city or town, state) <b>The Clinical Center</b>  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>GORDON C. SHARP</b>   |  |   |  | DATE SIGNED <b>1/28/60</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   |  | 22b. DATE THEREOF<br><b>2/1/60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Family</b>                     |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Southampton County, Va.</b>  |  |   |  |   |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W.W. Chambers Co.</b>   |  |   |  | ADDRESS<br><b>1400 Chapin St. N.W. Wash. D.C.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>FEB 1 '60</b>                             |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Knaus</b>   |  |   |  |   |  |   |  |

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00000

STATE OF CALIFORNIA

1920

Montgomery

13 days

13 days

13 days

The State of California, County of Santa Clara, ss.

I, the undersigned, a Notary Public in and for the State of California, do hereby certify that the within and foregoing is a true and correct copy of the original thereof as the same appears from the records of said County.

Witness my hand and seal of office at San Jose, California, this 10th day of January, 1920.

Notary Public in and for the State of California

John T. Smith

The Medical Society

100-10-20-20 The State of California, County of Santa Clara, ss.

Notary Public in and for the State of California

Notary Public in and for the State of California

Notary Public in and for the State of California

X

November 10, 1920

1920

1920

The Medical Society  
Notary Public in and for the State of California

Notary Public in and for the State of California



## 0882 CERTIFICATE OF DEATH

00810

Reg. Dist. No.

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Montgomery</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6121 Simple St</u>   |                               | d. STREET ADDRESS <u>6121 Simple St</u>  |   |
| 3. NAME OF DECEASED (Type or print) <u>THEMISTIE</u> First Middle Last <u>BORTZ</u>  |                               | 4. DATE OF DEATH <u>Jan 10</u> Month Day Year <u>1960</u>  |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 28 1887</u>           |
| 9. AGE (In years last birthday) <u>72</u> Yrs.   |                               | IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Ohio</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>John Edmund</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Ida Hilgard</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)   |                               | 16. SOCIAL SECURITY NO. <u>none</u>  |   |
| 17. INFORMANT <u>Frank E Bortz</u> Address <u>6121 Simple St Bethesda MD</u>   |                               |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Coronary Artery Disease</u><br>DUE TO (c) <u>Disease</u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u><br><u>Years</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>1936</u> , 19 <u>60</u> , to <u>Jan 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>60</u> , and that death occurred at <u>8:40</u> M, from the causes and on the date stated above.   |                               |  |   |
| ACTUAL SIGNATURE <u>R E Dunkley</u> M.D.   |                               | ADDRESS (Street, city or town, state) <u>1746 - R Street</u> DATE SIGNED   |   |
| PHYSICIAN'S NAME (Type) <u>R. E. Dunkley</u>   |                               |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF             | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u>  | <u>1/12/60</u>                | <u>Parklawn Cmn.</u>   | <u>Rockville Pike MD</u>                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chuan Fund Home</u> ADDRESS <u>5103 1/2 St NW Wash DC</u>  |                               | 24a. REC'D BY REGISTRAR DATE <u>JAN 12 1960</u>  |   |
|  |                               | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0875

Items 3, 13, 14, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

00811

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>26 Rockville</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1413 Bernerd Place</b>   |  | d. STREET ADDRESS<br><b>1 1413 Bernerd Place</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>AGOSTINO</b> (nmn) Middle <b>BORZELLO</b> Last <b>1</b>   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>13</b> Year <b>19 60</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>                 | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 7, 1877</b>                  |
| 9. AGE (In years last birthday)<br><b>82</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>8</b> | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Contractor</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Italy</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  |   |   |
| 13. FATHER'S NAME<br><b>Nick Borzello</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Rosea Pizzi</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>Mrs. Mazzio-daughter-1325 Dale Dr. Md</b>   |  | Address <b>Silver Spring</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1 Myocardial Infarction</b><br>DUE TO (b) <b>Coronary thrombosis</b><br>DUE TO (c) <b>Coronary arteriosclerosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr.</b><br><b>24 hrs</b><br><b>Indef.</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from the causes and on the date stated above.            |  |   |   |
| 22a. SIGNATURE<br><b>Stephen N. Jones</b>   |  | 22b. DATE SIGNED<br><b>1/14/60</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Stephen N. Jones</b>   |  | 22d. ADDRESS<br><b>Rockville, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>1/16/60</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>   |  | 25a. REC'D BY REGISTRAR<br><b>Bethesda, Maryland</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Thomas</b>   |  | DATE <b>JAN 15 '60</b>  |   |



## 0883 CERTIFICATE OF DEATH

Reg. Dist. No. 215

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Loretta</b> Middle <b>Ann</b> Last <b>BOWMAN</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>21</b> Year <b>1960</b>   |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Caucasian</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>12-7-99</b>   |  |
| 9. AGE (In years last birthday)<br><b>60</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  | 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- -</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>               |  |
| 13. FATHER'S NAME<br><b>George Whelan</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Anna Lenahan</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |  |  |
| INFORMANT<br><b>Hospital Records</b>  |  |   |  | Address   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Lymphatic Leukemia</b><br><b>204.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <b>January 20, 1960</b> , to <b>January 21, 1960</b> that I last saw the deceased alive on <b>January 21, 1960</b> , and that death occurred at <b>4:40 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital</b> DATE SIGNED <b>1-21-60</b>   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>R. G. Galbraith Jr.</b> M.D. <b>U.S. Naval Hospital</b> DATE SIGNED <b>1-21-60</b>  |  |   |  |   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>R.G. GALBRAITH JR., LT MC USN</b> <b>Bethesda, Maryland</b>  |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>1-25-60</b>           |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W.E. Pumphrey</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>JAN 25 60</b>   |  |  |  |
| ADDRESS<br><b>W.E. Pumphrey Funeral Home, Silver Spring, Md.</b>  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>W.E. Pumphrey</b>  |  |  |  |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. E. Kennedy, Hotel Home, Silver Spring, Md.

Serial 1-25-60

Washington National

Washington

Virginia

U. S. DEPARTMENT OF JUSTICE

Records, Washington

January 27, 1960

January 27, 1960

January 27, 1960

January 27, 1960

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## 0884 CERTIFICATE OF DEATH

Reg. Dist. No. 215

|   |  |   |  |  |  |                                 |  |
|---|--|---|--|--|--|---------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |                                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>  |  |   |  | c. LENGTH OF STAY IN 1b <b>19 days</b>   |  |                                 |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                 |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Frank</b> Middle <b>Mark</b> Last <b>BRADLEY</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>16</b> Year <b>19 60</b>   |  |                                 |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>Caucasian</b>                                       |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>6-24-82</b> |  |
| 9. AGE (In years lost birthday) <b>77</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. |  | IF UNDER 24 HRS.<br>Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.   |  |                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>   |  |                                 |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |                                 |  |
| 13. FATHER'S NAME <b>Dennis K. Bradley</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Catherine Tahney</b>   |  |                                 |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO. <b>(SinL) Iven O. Irwin, same as #2 above</b>  |  |                                 |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Obstructive Jaundice</b><br>154X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma with Hepatic Involvement 4 mo.</b><br>DUE TO (c) <b>Adenocarcinoma, rectosigmoid 4 mo. to 1 yr.</b> |  |   |  |  |  |                                 |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |                                 |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |                                 |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>                               |  |                                 |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  | 20f. (City or town) (County) (State)   |  |                                 |  |
| 21. I certify that I attended the deceased from <b>December 29, 1959</b> , to <b>January 16, 1960</b> , that I last saw the deceased alive on <b>January 15, 1960</b> , and that death occurred at <b>3:30A</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>1-16-60</b>   |  |   |  |  |  |                                 |  |
| ACTUAL SIGNATURE <b>John Wood Davis</b>   |  |   |  | PHYSICIAN'S NAME (Type) <b>John Wood DAVIS, LT, MC, USN</b>  |  |                                 |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |   |  | 22b. DATE THEREOF <b>1-19-60</b>   |  |                                 |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>   |  |   |  | 22d. LOCATION (City, town, or county) (State) <b>Long Green Maryland</b>   |  |                                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Cook Funeral Home, 1703 N. Patterson Pk. Ave.</b>  |  |   |  | 24a. REC'D BY REGISTRAR <b>IAN 1 9 '60</b>   |  |                                 |  |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>   |  |   |  |  |  |                                 |  |

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TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Massachusetts</b> b. COUNTY <b>Lowell</b>  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>  |  |   |  | c. LENGTH OF STAY IN 1b <b>27 days</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>   |  |   |  | d. STREET ADDRESS <b>61 West Albert Street</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Melanie</b> Middle <b>Elizabeth</b> Last <b>Brady</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>31</b> Year <b>1960</b>   |  |  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>January 11, 1941</b>   |  |
| 9. AGE (In years last birthday) <b>19</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min. |  | IF UNDER 24 HRS.<br>Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student (None)</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>                                 |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  |   |  | 13. FATHER'S NAME <b>Roger M. Brady</b>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME <b>Anne Kostecka</b>   |  |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |  |  |  |
| 16. SOCIAL SECURITY NO. <b>None</b>   |  |   |  | INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>334x Cardio respiratory failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral edema</b><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hours</b><br><b>60 hours</b> |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |
| 20f. (City or town) _____ (County) _____ (State) _____  |  |   |  | 21. I certify that I attended the deceased from <b>January 4, 1960</b> to <b>January 31, 1960</b> , that I last saw the deceased alive on <b>January 31, 1960</b> , and that death occurred at <b>3:40 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>The Clinical Center, Bethesda 14, Maryland</b> DATE SIGNED <b>1/31/60</b> |  |  |  |
| ACTUAL SIGNATURE <b>Don A. MacCubbin</b>  |  |   |  | PHYSICIAN'S NAME (Type) <b>DON A. MACCUBBIN, M. D.</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. Trans.</b>  |  |   |  | 22b. DATE THEREOF <b>2/1/60</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Lowell Cemetery</b>                                      |  |
| 22d. LOCATION (City, town, or county) <b>Lowell, Massachusetts</b>  |  |   |  | (State) _____   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>  |  |   |  | 24a. REC'D BY REGISTRAR <b>FEB 4 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>  |  |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL EXHIBIT

History: Patient is a 45-year-old male, white, with a long history of chronic obstructive pulmonary disease (COPD) and a recent diagnosis of emphysema. He has been a heavy smoker for over 30 years. He has been hospitalized several times in the past year for respiratory failure and pneumonia. He is currently on long-term oxygen therapy and has been prescribed a course of antibiotics for a recent respiratory infection. He is being admitted to the hospital for further evaluation and management of his respiratory condition.

Physical Examination: On admission, the patient is found to be in moderate distress. He is a well-developed male with a body mass index (BMI) of 28. His vital signs are: temperature 38.2°C, heart rate 110 bpm, respiratory rate 22 breaths per minute, and oxygen saturation 88% on room air. He has hyperinflated lungs with decreased breath sounds and increased wheezing throughout both lung fields. There is no crackles or rhales. His heart is normal in size and rhythm. His abdomen is soft and non-tender. His neurological examination is within normal limits.

Investigations: A chest X-ray shows hyperinflation of the lungs with flattened diaphragms and increased retrosternal air space, consistent with emphysema. There is no evidence of pneumonia or pleural effusion. A sputum culture is sent and shows no growth. A complete blood count (CBC) shows a mild anemia with hemoglobin 12.5 g/dL and hematocrit 37.5%. A basic metabolic panel (BMP) shows a normal electrolyte panel with sodium 138 mEq/L, potassium 4.2 mEq/L, calcium 9.8 mg/dL, and bicarbonate 24 mEq/L. Arterial blood gas (ABG) analysis shows a partial pressure of oxygen (PO2) of 65 mmHg, partial pressure of carbon dioxide (PCO2) of 45 mmHg, and pH of 7.35.

Diagnosis: The patient's clinical presentation, physical examination, and investigations are consistent with a diagnosis of chronic obstructive pulmonary disease (COPD) with emphysema. He is also being treated for a recent respiratory infection.

Management: The patient is being managed with a combination of medical and non-medical interventions. He is receiving long-term oxygen therapy and has been prescribed a course of antibiotics. He is also being treated with a combination of inhaled corticosteroids and long-acting beta2-agonists (LABA) for his COPD. He is being encouraged to quit smoking and is being referred to a smoking cessation program. He is also being educated about the importance of regular follow-up and the signs and symptoms of a respiratory exacerbation.

January 2, 1960  
The National Center  
National Institute of Health  
Bethesda, Maryland

Dr. J. A. Thompson, M.D.  
Department of Medicine  
The National Center  
National Institute of Health  
Bethesda, Maryland

## CERTIFICATE OF DEATH

Reg. Dist. No.

00815

0823

|  |                               |   |                                     |   |  |   |  |
|--|-------------------------------|---|-------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                               |   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>  |                               |   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase 58</u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen. and Hospital</u>   |                               |   |                                     | d. STREET ADDRESS <u>7409 Ridge Wood Ave</u>  |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Genevieve</u> Middle <u>Mae</u> Last <u>Brandt</u>  |                               |   |                                     | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>1960</u>   |  |   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH <u>Jan. 4 1869</u> |   | 9. AGE (In years last birthday) <u>91</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min.                                  | IF UNDER 24 HRS. Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |                                     | 11. BIRTHPLACE (State or foreign country) <u>Illinois</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>                               |  |
| 13. FATHER'S NAME <u>Henry Frost</u>   |                               |   |                                     | 14. MOTHER'S MAIDEN NAME <u>Martha Palmer</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>None</u>   |                                     | INFORMANT <u>W.S. Hospital Records-</u>   |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Arteriosclerotic heart disease &amp; Hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe degenerative x-v Blch</u> DUE TO <u>?</u><br>(c) <u>Coronary failure</u> DUE TO <u>2 y</u> |                               |   |                                     |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                               |   |                                     |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that I attended the deceased from <u>April 4 - 1959</u> , to <u>Jan. 21, 1960</u> , that I last saw the deceased alive on <u>Jan. 21, 1960</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.  |                               |   |                                     |   |  |   |  |
| ACTUAL SIGNATURE <u>Chas H. Wolohin</u>  |                               |   |                                     | ADDRESS (Street, city or town, state) <u>500 Underwood St NW</u>  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>CHAS H. WOLOHIN</u>   |                               |   |                                     | DATE SIGNED <u>500 Underwood St NW</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>1/23/60</u>  |                                     | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>  |                               |   |                                     | 24a. REC'D BY REGISTRAR <u>JAN 25 '60</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>                       |  |

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

00816

0886

|  |                                  |   |  |  |   |  |  |
|--|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>3 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>d. STREET ADDRESS<br><b>4609 Chestnut Street</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Charles Henry Brinker</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>January 9 1960</b>   |  |  |   |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 15, 1893</b>        |  | 9. AGE (In years last birthday)<br><b>66</b> yrs.   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Government</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                  |   |  |  |   |  |  |
| 13. FATHER'S NAME<br><b>Frank Brinker</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Shoher</b> |  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>XXIIWWI</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>WW-I--578-32-1402</b>   |  | 17. INFORMANT<br><b>The Medical Record</b><br>Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction and Atelectasis, Rt. Lung.</b><br>DUE TO<br><b>420.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Coronary Artery Thrombosis and Carcinomatosis.</b><br>DUE TO<br>(c) <b>?</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>7 Months</b> |                                  |   |  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  |  |   |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |   |  |  |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   |  |  |
|  |                                  |   |  | 20f. (City or town) (County) (State)   |   |  |  |
| 21. I certify that I attended the deceased from <b>January 6, 1960</b> , to <b>January 9, 1960</b> , that I last saw the deceased alive on <b>January 9, 1960</b> , and that death occurred at <b>9:10a</b> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b><br>DATE SIGNED<br><b>1-9-60</b>   |                                  |   |  |  |   |  |  |
| ACTUAL SIGNATURE <b>Saul Genuth</b><br>M.D. <b>The Clinical Center</b><br>PHYSICIAN'S NAME (Type) <b>SAUL GENUTH, M.D.</b><br><b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>   |                                  |   |  |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>1-12-60</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cem.</b>   |   |  |  |
|  |                                  |   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Silver Spring, Maryland</b>  |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>  |                                  |   | 24a. REC'D BY REGISTRAR<br><b>JAN 11 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b> |  |  |

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0288

Montgomery

Maryland

Patricia

3 days

1609 Chestnut Street

The Clinical Center, Bethesda II, Md.

Patricia

Henry

Charles

66

MAY 15, 1952

White

Male

Maryland

Government

Black

Henry Strober

Trans. Station

The Medical Record

575-32-1102 The Clinical Center, Bethesda II, Maryland

Occasional laboratory and statistical data.

University of Maryland and Johns Hopkins.

January 2, 60

January 6

60

January 7

3-2-60

The Clinical Center

National Institutes of Health

Bethesda II, Maryland

SALE ORDER, N.O.

Gate of Heaven Cam. Silver prints, Maryland

1-12-60

Serial

Robert A. Murphy, Bethesda, Maryland

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00817

|  |                                |   |                                      |  |   |   |  |
|--|--------------------------------|---|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND  |                                |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>md</i> b. COUNTY <i>montg</i> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rockville - R-22</i>  |                                | c. LENGTH OF STAY IN 1b<br><i>13 yrs</i>  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rockville - R-22</i>                        |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Fallen Rd.</i>  |                                |   |                                      | d. STREET ADDRESS<br><i>Fallen Rd</i>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Lina</i> Middle <i>Ozan</i> Last <i>Brothers</i>   |                                |   |                                      | 4. DATE OF DEATH<br>Month <i>Jan</i> Day <i>31</i> Year <i>1960</i>  |   |   |  |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>col</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>7-25-1918</i> | 9. AGE (In years last birthday)<br><i>41</i> yrs.  | IF UNDER 1 YEAR<br>Months <i>4</i> Days <i>1</i> Hours <i>1</i> Min. <i>0</i> |   | IF UNDER 24 HRS.<br>Hours <i>1</i> Min. <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>housewife</i>  |                                | 10b. KIND OF BUSINESS OR INDUSTRY   |                                      | 11. BIRTHPLACE (State or foreign country)<br><i>Haiti</i>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>Haiti</i>  |  |
| 13. FATHER'S NAME<br><i>unknown</i>  |                                |   |                                      | 14. MOTHER'S MAIDEN NAME<br><i>unknown</i>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>  |                                | 16. SOCIAL SECURITY NO.   |                                      | 17. INFORMANT<br><i>Maize Brothers -</i>   |   | Address <i>Stuen 2</i>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary occlusion</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i><br>DUE TO (c)   |                                |   |                                      |  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                |   |                                      |  |   |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <i>19</i> p. m.  |                                | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                |   |                                      |  |   |   |  |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i>   |                                |   |                                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   |  |
| EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>   |                                |   |                                      | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |   |  |
|  |                                |   |                                      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Buried</i>   |                                | 22b. DATE THEREOF<br><i>1-10-60</i>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><i>Lincoln Natl Cem</i>  |   | 22d. LOCATION (City, town, or county) (State)<br><i>Rockville md.</i>                             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Robert L. Menden</i>  |                                |   |                                      | 24a. REC'D BY REGISTRAR<br>DATE <i>FEB 9 '60</i>   |   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kline</i>  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

EXAMINER'S  
STATE DEPT.

11

11

11

11

11

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is divided into several columns and rows, with checkboxes for various conditions and a large section for the medical examiner's signature and stamp.



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

Washington, D. C.

January 10, 1910

Mr. J. H. ...

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 8th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours very truly,

Wm. B. ...

Enclosed for you are two copies of the report of the ...

Very respectfully,  
Wm. B. ...

...

...

...

...

...

...

...



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00819

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|  |  |  |   |  |   |  |  |
|--|--|--|---|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <span style="float: right;">0803</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b><br>c. LENGTH OF STAY IN 1b<br><b>56</b> <b>SILVER SPRING</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY COUNTY POLICE STATION</b>   |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>703 UNIVERSITY BLVD., WEST</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>LEO</b> <b>ARTHUR</b> <b>BRYER</b>  |  |  | 4. DATE OF DEATH<br>Month <b>JAN.</b> Day <b>6</b> Year <b>1960</b> |  |   |  |  |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>   |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |   |  |  |
| 8. DATE OF BIRTH<br><b>11-12-08</b>  |  | 9. AGE (In years last birthday)<br><b>50</b> yrs.  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>President</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>REAL ESTATE</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>New York City, N.Y.</b>  |   |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Ernest Bryer</b>   |   |  |   |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Fannie Burger</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>                                 |   |  |   |  |  |
| 16. SOCIAL SECURITY NO.<br><b>---</b>  |  | 17. INFORMANT Address<br><b>Mrs. Leah Bryer - 703 University Blvd. W.S.S.Md.</b>                             |   |  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cornary occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. DUE TO (c)   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b>   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                 |   |  |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>of work of work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   |  |  |
| 20f. (City or town)<br><b>Falls Church, Virginia</b>   |  | 20g. (County) (State)  |   |  |   |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |   |  |   |  |  |
| ACTUAL SIGNATURE<br><b>Frank J. Broschart</b>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | DATE SIGNED  |   |  |  |
| EXAMINER'S NAME (Type)<br><b>FRANK J. BROSCART</b>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   | <b>1-6-60</b>  |   |  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | <b>1-6-60</b>  |   |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>Jan. 8, 1960</b>   |   | 22c. NAME OF CEMETERY OR CREMATION<br><b>King David Memorial Garden</b>  |   |  |  |
| 22d. LOCATION (City, town, or county)<br><b>Falls Church, Virginia</b>   |  | (State)  |   |  |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. Danzansky &amp; Sons - 3501 14th St., N. W.</b>  |  | ADDRESS  |   | 24a. REC'D BY REGISTRAR<br><b>Arthur S. Evans</b>  |   |  |  |
| 24b. REGISTRAR'S SIGNATURE   |  | DATE <b>JAN 12 '60</b>   |   |  |   |  |  |

MEDICAL CERTIFICATION

0803

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

DECEASED

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

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DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0889 CERTIFICATE OF DEATH

00820

Reg. Dist. No.

|   |                                  |   |   |   |   |  |                  |
|---|----------------------------------|---|---|---|---|--|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |   |  |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rt. 3 Box 15</b>   |                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rt. 3 Box 15</b>                                       |   |  |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Gaithersburg</b>   |                                  |   |   | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |                  |
| 3. NAME OF DECEASED (Type or print)<br><b>JOSIE G. BURDETTE</b>   |                                  |   |   | 4. DATE OF DEATH<br><b>Jan 15 1960</b>  |   |  |                  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 29 1884</b> | 9. AGE (In years last birthday)<br><b>75</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Labor</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>        |                  |
| 13. FATHER'S NAME<br><b>William W. Burdette</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Lawson</b>  |   |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>579 07 0932</b>   |   | 17. INFORMANT<br><b>Harry C. Burdette</b>   |   | Address<br><b>Same As 2</b>                          |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____                    |                                  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Not Known</b> |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                                  |   |   |   |   |  |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                 |                  |
| 21. I certify that I attended the deceased from <b>1957</b> , 19, to <b>Jan. 14, 1960</b> , that I last saw the deceased alive on <b>Jan. 13, 1960</b> , and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Gaithersburg, Md.</b> DATE SIGNED <b>1-16-60</b> |                                  |   |   |   |   |  |                  |
| ACTUAL SIGNATURE <b>Jack Schumacker</b> M.D.  |                                  |   |   | PHYSICIAN'S NAME (Type) <b>Jack Schumacker</b>  |   |  |                  |
| 22a. BURIAL, CREMATION, or other disposition (Specify)  |                                  | 22b. DATE THEREOF   |   | 22c. NAME OF CEMETERY OR CREMATORY  |   | 22d. LOCATION (City, town, or county) (State)        |                  |
| <b>Brownsville</b>  |                                  | <b>Jan 18 1960</b>  |   | <b>Brownsville</b>  |   | <b>Md</b>  |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Francis H. Barber</b>  |                                  |   |   | ADDRESS<br><b>Laytonsville, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 19 1960</b>   |                  |
|   |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Knapp</b>  |   |  |                  |

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| <p>1. NAME OF DECEASED<br/>                 [Faint text]</p>        |  | <p>2. SEX<br/>                 [Faint text]</p>                   |  | <p>3. AGE<br/>                 [Faint text]</p>                    |  |
| <p>4. DATE OF DEATH<br/>                 [Faint text]</p>           |  | <p>5. TIME OF DEATH<br/>                 [Faint text]</p>         |  | <p>6. PLACE OF DEATH<br/>                 [Faint text]</p>         |  |
| <p>7. CAUSE OF DEATH<br/>                 [Faint text]</p>          |  | <p>8. MANNER OF DEATH<br/>                 [Faint text]</p>       |  | <p>9. SIGNATURE OF PHYSICIAN<br/>                 [Faint text]</p> |  |
| <p>10. SIGNATURE OF REGISTRAR<br/>                 [Faint text]</p> |  | <p>11. SIGNATURE OF WITNESS<br/>                 [Faint text]</p> |  | <p>12. SIGNATURE OF DECEASED<br/>                 [Faint text]</p> |  |

1. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the [Faint text] day of [Faint text], 19[ Faint text].

2. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the [Faint text] day of [Faint text], 19[ Faint text].

3. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the [Faint text] day of [Faint text], 19[ Faint text].

CERTIFICATE OF DEATH

00821

Reg. Dist. No.

|  |  |   |  |   |  |  |  |  |  |   |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>  |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b> |  | c. LENGTH OF STAY IN 1b<br><b>81 days</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>West Virginia</b><br>b. COUNTY<br><b>Blair</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>85X-3</b> |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b> |  |   |  |   |  | d. STREET ADDRESS<br><b>No street address</b>  |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>Ronald</b>  |  | Middle<br><b>Dale</b>   |  | Last<br><b>Burgess</b>  |  | 4. DATE OF DEATH<br>Month<br><b>January</b>  |  | Day<br><b>16</b>   |  | Year<br><b>1960</b>   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>August 7, 1956</b>  |  | 9. AGE (In years last birthday)<br><b>3</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months<br><b>3</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Child</b>                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Carl Burgess</b>   |  |   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Maudie Ellis</b>  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | INFORMANT <b>The Medical Record</b> Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |  |  |  |  |  |   |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>197.9</b><br>DUE TO<br><b>Respiratory insufficiency</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br><b>Rhabdomyosarcoma</b><br>DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b><br><b>9 months</b> |  |
|---|--|--|--|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)                   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
|  |  | 20f. (City or town)   |  | (County) (State)  |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 21. I certify that I attended the deceased from <b>October 27, 1959</b> to <b>January 16, 1960</b> that I last saw the deceased alive on <b>January 16, 1960</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above. |  |  |  |   |  |
| ACTUAL SIGNATURE<br><i>Lawrence A. Gaydos</i>  |  |  |  | ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b> |  |
| PHYSICIAN'S NAME (Type)<br><b>Lawrence A. Gaydos, M. D.</b>  |  |  |  | DATE SIGNED<br><b>1/17/60</b>                                       |  |
|  |  |  |  | <b>National Institutes of Health</b>                                |  |
|  |  |  |  | <b>Bethesda 14, Maryland</b>  |  |

|   |  |                                     |  |   |  |   |  |
|---|--|-------------------------------------|--|---|--|---|--|
| 22a. DATE OF CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 22b. DATE THEREOF<br><b>1/17/60</b> |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>White Oak Cemetery</b> |  | 22d. LOCATION (City, town, or county) (State)<br><b>Blair West Virginia</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>The S.H. Jones Co.</i> |  |                                     |  | ADDRESS<br><i>2991 14th St. N.W. Washington D.C.</i>            |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 19 '60</b>                           |  |
|   |  |                                     |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur L. Kraus</i>                        |  |

TO HOSPITAL, AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

West Virginia

Residence

State

in days

Residence

The Clinical Center, Bethesda, Md., No record address

Home Address Date Bureau January 15 60

White White August 7, 1958

White West Virginia U.S.A.

Carl Engstrom

None The Clinical Center, Bethesda, Md., Maryland

Residence Transitory days

Residence

January 15 60 October 27 59 January 15 60

Residence A. Leggett, Jr. The Clinical Center National Institute of Health Bethesda, Md., Maryland

Residence West Virginia





UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE  
BUREAU OF VITAL STATISTICS  
STATE OF NEW YORK  
CERTIFICATE OF DEATH

Decedent's Name

Place of Birth

County of Residence

Occupation

Date of Death

Time of Death

Place of Death

Physician's Name

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Nurse

Signature of Undertaker

Signature of Burial Director

Signature of Cemetery Superintendent

Signature of Interment Agent

Signature of Funeral Home

Signature of Mortuary

Signature of Embalmer

Signature of Crematorium

MEDICAL CERTIFICATION

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Montgomery</b>  |  | • MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>Maryland</b>  |  | b. COUNTY<br><b>Montgomery</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  | c. LENGTH OF STAY IN 1b<br><b>15 days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>56 Silver Spring</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |  |   |  | d. STREET ADDRESS<br><b>13413 Clifton Drive</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)   |  | First<br><b>Cary</b>  |  | Middle<br><b>Elizabeth</b>  |  | Last<br><b>Butler</b>   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>June 1, 1959</b>   |  |
|  |  |   |  | 9. AGE (In years last birthday)<br>yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>6</b>  |  |
|  |  |   |  |   |  | Hours <b></b> Min. <b></b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Child</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Warren L. Butler</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lila Bowen</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | INFORMANT <b>The Medical Record</b> Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |   |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b>   |  |   |  |   |  |   |  |
| 754.5 DUE TO   |  |   |  |   |  |   |  |
| (b) <b>Congenital heart disease, cyanotic</b>  |  |   |  |   |  |   |  |
| DUE TO   |  |   |  |   |  |   |  |
| (c)  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>December 22, 1959</b> , to <b>January 6, 1960</b> , that I last saw the deceased alive on <b>January 6, 1960</b> , and that death occurred at <b>11:09 P.</b> M, from the causes and on the date stated above |  |   |  |   |  |   |  |
| ADDRESS (Street, city or town, state) DATE SIGNED<br><b>The Clinical Center 1-7-60</b>   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Lowell K. Good</b>  |  | M.D. <b>The Clinical Center</b>   |  |   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>Lowell K. Good</b>   |  | M.D. <b>National Institutes of Health</b>   |  |   |  |   |  |
|  |  | <b>Bethesda 14, Maryland</b>  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |  | 22b. DATE THEREOF<br><b>1-8-60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Prince George Co., Md.</b>                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>ROBERT A. PUMPHREY</b>  |  |   |  | ADDRESS<br><b>Bethesda, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 '60</b>   |  |
|  |  |   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>  |  |



0833

CERTIFICATE OF DEATH

00824

Reg. Dist. No.

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>M ontg omery</b> <b>MARYLAND</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |                               | c. LENGTH OF STAY IN 1b <b>39 hrs.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <b>Man uel</b>   |                               | 4. DATE OF DEATH <b>Jan. 18 19 60</b>  |   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>8/25/86</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Economic research</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>Spain</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |   |
| 13. FATHER'S NAME <b>Hieronamo Calvo</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>M aria Laprida</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                               | 16. SOCIAL SECURITY NO. <b>None</b>  |   |
| 17. INFORMANT <b>Wife (Same as Above)</b>  |                               | Address <b>Nettie Calvo</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchiogenic carcinoma - 162.1</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <b>8 mos</b> |                               |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Jan 13</b> , 19 <b>60</b> , to <b>Jan 18</b> , 19 <b>60</b> , that I lost sow the deceased olive on <b>Jan 13</b> , 19 <b>60</b> , and that death occurred at <b>1:15 A</b> M, from the causes ond on the date stated above.<br>ADDRESS (Street, city or town, state) <b>10511 Summit Ave Kensington, Md</b><br>DATE SIGNED _____<br>ACTUAL SIGNATURE <b>Horace W. Berton</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Horace N. Berton</b>                                 |                               |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>1/21/60</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>   |                               | 24a. REC'D BY REGISTRAR <b>JAN 22 '60</b>  |   |
| ADDRESS <b>Bethesda, Maryland</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>   |   |

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

0000

MAILED  
JAN 10 1900





0894

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|  |                                  |   |   |  |   |  |  |
|--|----------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN 1b<br><b>8 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, Bethesda Md.</b>                 |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Illinois</b><br>b. COUNTY<br><b>West Chicago</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>West Chicago</b><br>d. STREET ADDRESS<br><b>308 Grand Lake Blvd.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>Edward</b><br>Middle<br><b>Daniel</b><br>Last<br><b>CAREY</b>   |                                  |   | 4. DATE OF DEATH<br>Month<br><b>January</b><br>Day<br><b>4</b><br>Year<br><b>1960</b> |  |   |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-7-07</b>  |  | 9. AGE (In years last birthday)<br><b>52</b> yrs.                                     |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U.S. Marine Corps</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Government</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Illinois</b>   |   |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                                  |   | 13. FATHER'S NAME<br><b>unknown</b>   |  |   |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>   |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>      |  |   |  |  |
| 16. SOCIAL SECURITY NO.<br><b>(Sister) Same as #2 Mary G. Carey</b>  |                                  |   | 17. INFORMANT<br><b>(Sister) Same as #2 Mary G. Carey</b>                             |  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bleeding Esophageal Varices</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Portal Hypertension</b><br>DUE TO<br>(c) <b>Laennec's Cirrhosis</b> |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 days</b><br><b>2 years</b><br><b>5 years</b> |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |   |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   |  |  |
| 20f. (City or town)  |                                  | (County)  |   | (State)  |   |  |  |
| 21. I certify that I attended the deceased from <b>27 December, 1959</b> , to <b>4 January, 1959</b> , that I last saw the deceased alive on <b>4 January, 1959</b> , and that death occurred at <b>7:40 A</b> M, from the causes and on the date stated above.  |                                  |   |   |  |   |  |  |
| ACTUAL SIGNATURE<br><b>John Wood Davis</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>U.S. Naval Hospital, Bethesda Md. 1-4-60</b>  |   |  |   |  |  |
| PHYSICIAN'S NAME (Type)<br><b>J.W. Davis LT MC USN</b>   |                                  | U.S. Naval Hospital, Bethesda Md.   |   |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>1-7-60</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>  |   |  |  |
| 22d. LOCATION (City, town, or county)<br><b>West Chicago, Ill.</b>   |                                  | (State)   |   | 22e. REC'D BY REGISTRAR<br><b>DATE JAN 7 '60</b>   |   |  |  |
| 22f. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                  | 22g. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |   |  |   |  |  |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cornea papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

UNITED STATES OF AMERICA

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MEDICAL CERTIFICATION

VR A15 (4)  
15M 9/59

0086

3838 CENTINAT OCEAN

Montgomery

Marshall

Kenneth

11 years

2841 Locust Avenue

2841 Locust Avenue

DAVID L. ALEXANDER

January 15

June

Virginia

1 baby

Baby

Early Age

Early Age

214-2-1000 214-2-1000 214-2-1000

214-2-1000 214-2-1000 214-2-1000

X

214-2-1000

214-2-1000

X

214-2-1000

214-2-1000

214-2-1000

## CERTIFICATE OF DEATH

Reg. Dist. No.

00827

0824

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TAKOMA PARK</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>10 yrs.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>520 PHILADELPHIA AVE.</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CATHERINE</b> Middle <b>A.</b> Last <b>CARR</b>  |                                  | 4. DATE OF DEATH<br>Month <b>JAN.</b> Day <b>27</b> Year <b>1960</b>  |   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>JULY 21, 1885</b>    |
| 9. AGE (In years lost birthday)<br><b>74</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.  | 11. IF UNDER 24 HRS.<br>Hours <b>1</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CLERK</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. GOV'T.</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>WASHINGTON, D.C.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>WILLIAM E. CARR</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET QUIGLEY</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> [If yes, give war or dates of service]  |                                  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |   |
| 17. INFORMANT<br><b>Miss Margaret Carr, 520 Philadelphia Ave. Takoma Park, Maryland</b>  |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b><br><b>480 X</b> DUE TO <b>lobar pneumonia Rt lower lobe</b><br><b>Influenza</b><br><b>Coronary Arterio-sclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Thromboses (old) (3)</b> DUE TO (c) <b>Chronic generalized Arterio sclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic generalized Arterio sclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>8 days</b><br><b>1940</b><br><b>Jan 19 58</b><br><b>Jan 19 59</b> |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b> p. m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Mar 5</b> , 19 <b>51</b> , to <b>Jan 27</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 26</b> , 19 <b>60</b> , and that death occurred at <b>10:00</b> A.M., from the causes and on the date stated above.   |                                  |   |   |
| ACTUAL SIGNATURE <b>George L. Ball</b>   |                                  | ADDRESS (Street, city or town, state) <b>10620 Georgia Ave Jan 27, 1960</b>   |   |
| PHYSICIAN'S NAME (Type) <b>George L. Ball</b>  |                                  | Silver Spring Md  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>1/30/60</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>MT. OLIVET CEMETERY</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>WASHINGTON, D.C.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PUMPHREY, INC.</b><br><b>Raymond A. Ziska</b>   |                                  | ADDRESS<br><b>SILVER SPRING, MD.</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>JAN 29 '60</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kram</b>   |   |

STATE OF TEXAS

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COUNTY

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00828

|  |  |                                  |  |  |  |  |  |
|--|--|----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>                |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>  |  |                                  |  | c. LENGTH OF STAY IN 1b  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Co. General Hos.</b>  |  |                                  |  | d. STREET ADDRESS <b>Highland</b> 13x-2  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>SUZANNE CARTER</b> First Middle Last  |  |                                  |  | 4. DATE OF DEATH <b>Jan. 31 1960</b> Month Day Year  |  |  |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>    |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Dec. 10, 1959</b>                                  |  |
| 9. AGE (In years lost birthday) yrs. <b>1</b>  |  | IF UNDER 1 YEAR Months <b>21</b> |  | IF UNDER 24 HRS. Days <b>21</b>  |  | Hours <b>1</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>  |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Olney, Maryland</b>   |  |                                  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |  |
| 13. FATHER'S NAME <b>John Carter</b>   |  |                                  |  | 14. MOTHER'S MAIDEN NAME <b>Alice Diotte</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |  |                                  |  | 16. SOCIAL SECURITY NO. <b>None</b>  |  | 17. INFORMANT <b>John Carter, Highland, Md</b> Address                 |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral broncho pneumonia, both lower lobes.</b><br>DUE TO <b>774X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b><br>DUE TO (c) _____<br>INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b><br><b>6 weeks</b> |  |                                  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |                                  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |                                  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) _____ (County) _____ (State) _____   |  |                                  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>Dec. 10, 1959</b> to <b>Jan. 31, 1960</b> , that I last saw the deceased alive on <b>Jan. 31, 1960</b> , and that death occurred at <b>9 a</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Clarksville, Maryland</b> DATE SIGNED <b>1-31-60</b>  |  |                                  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Charles S. Whitaker, M.D.</b>  |  |                                  |  | PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>2-1-60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Gates of Heaven</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Wheaton, Md</b>       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higginbotham, Ellicott City, Md.</b> ADDRESS  |  |                                  |  | 24a. REC'D BY REGISTRAR <b>FEB 3 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Caring L. Kraus</b>                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073352XVI

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

|  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED<br><b>JOHN BARTON</b>            |  | 2. SEX<br><b>Male</b>                              |  | 3. AGE<br><b>35</b>                              |  | 4. DATE OF BIRTH<br><b>Jan. 10, 1922</b>         |  | 5. PLACE OF BIRTH<br><b>Johns River, Virginia</b> |  |
| 6. OCCUPATION<br><b>None</b>                         |  | 7. MARITAL STATUS<br><b>Single</b>                 |  | 8. COLOR<br><b>White</b>                         |  | 9. HEIGHT<br><b>5' 10"</b>                       |  | 10. WEIGHT<br><b>150 lbs.</b>                     |  |
| 11. CAUSE OF DEATH<br><b>Heart Disease</b>           |  | 12. MANNER OF DEATH<br><b>Natural</b>              |  | 13. PLACE OF DEATH<br><b>Home</b>                |  | 14. DATE OF DEATH<br><b>Jan. 10, 1952</b>        |  | 15. TIME OF DEATH<br><b>10:30 AM</b>              |  |
| 16. SIGNATURE OF PHYSICIAN<br><b>Dr. J. H. Smith</b> |  | 17. SIGNATURE OF REGISTRAR<br><b>John H. Smith</b> |  | 18. SIGNATURE OF WITNESS<br><b>John H. Smith</b> |  | 19. SIGNATURE OF WITNESS<br><b>John H. Smith</b> |  | 20. SIGNATURE OF WITNESS<br><b>John H. Smith</b>  |  |

## 0856 CERTIFICATE OF DEATH

Reg. Dist. No. 215

00829

|   |                                      |  |  |  |  |
|---|--------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <del>MD</del> <b>Virginia</b> b. COUNTY <b>Arlington</b> ✓ |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |                                      |  | c. LENGTH OF STAY IN 1b<br><b>8 1/2 hrs.</b>   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>   |                                      |  | d. STREET ADDRESS<br><b>6150 Wolson Blvd. N.</b>   |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Anne</b> Middle <b>Constance</b> Last <b>CHARBONNET</b>   |                                      |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>25</b> Year <b>1960</b>  |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Caucasian</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-24-60</b>   |  | 9. AGE (In years lost birthday) yrs. <b>8</b> Min. <b>29</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br>- - - - -   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                 |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                      |  |  |  |  |
| 13. FATHER'S NAME<br><b>Pierre N. CHARBONNET, JR.</b>   |                                      |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary DUTTON</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown)<br><b>No</b>  |                                      | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | INFORMANT Address<br><b>Hospital Records</b>                                 |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Immaturity</b><br><b>776x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Prematurity</b> DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____  |                                      |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 hrs.</b>            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. _____ p. m. _____ 19 _____   |                                      | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>                       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ |  |
|   |                                      | 20f. (City or town) _____ (County) _____ (State) _____   |  |  |  |
| 21. I certify that I attended the deceased from <b>January 24</b> , 19 <b>60</b> , to <b>January 25</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>January 25</b> , 19 <b>60</b> , and that death occurred at <b>7:35 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED _____<br>ACTUAL SIGNATURE <b>H. L. Walton</b> M.D. <b>U. S. Naval Hospital</b> <b>1-25-60</b><br>PHYSICIAN'S NAME (Type) <b>H. L. WALTON, LT, MC, USN</b> <b>Bethesda 14, Maryland</b> |                                      |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                      | 22b. DATE THEREOF<br><b>1-28-60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>              |  |
|   |                                      |  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. A. Pumphrey Funeral Home, Bethesda, Md.</b>   |                                      |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 27 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>         |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
 1946  
 1-24-46

Washington  
 (Aerial)  
 U. S. Naval Hospital  
 1-24-46

CHAMBERLAIN  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0897

CERTIFICATE OF DEATH

00830

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>WASHINGTON, D.C.</u> b. COUNTY <u>47X-3</u>         |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BROOKE GROVE FOUNDATION</u>  |  | d. STREET ADDRESS <u>3801 Connecticut Ave</u>  |  |
| 3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>ANN E.</u> Last <u>CLARKE</u>   |  | 4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1960</u>  |  |
| 5. SEX <u>FEMALE</u>   | 6. COLOR OR RACE <u>WHITE</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/21/1872</u>                                 |
| 9. AGE (In years last birthday) <u>87</u> yrs.   |  | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>  | IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>   | 11. BIRTHPLACE (State or foreign country) <u>CANADA</u>            |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  | 13. FATHER'S NAME <u>WILLIAM EARLE</u>   |  |
| 14. MOTHER'S MAIDEN NAME <u>ELIZA GRAHAM</u>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-----</u>                         |  |
| 16. SOCIAL SECURITY NO. <u>None</u>  |  | 17. INFORMANT <u>Mrs Phillip Olin Williamson, W. VA</u> Address <u>510 Dickinson St</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u><br><u>422.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO<br>(c) <u>  </u> |  | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                               |
| 21. I certify that I attended the deceased from <u>2/7/59</u> , 19 <u>  </u> , to <u>1/4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/4</u> , 19 <u>60</u> , and that death occurred at <u>10:45 P.M.</u> M, from the causes and on the date stated above.  |  |  |  |
| ACTUAL SIGNATURE <u>Ad Bryant</u>  |  | ADDRESS (Street, city or town, state) <u>Sandy Spring</u> DATE SIGNED <u>1/4/60</u>  |  |
| PHYSICIAN'S NAME (Type) <u>A.D. BUNIFANT</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>   | 22b. DATE THEREOF <u>1-5-60</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>FORREST LAWN</u>   | 22d. LOCATION (City, town, or county) (State) <u>SAGINAW MICH.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hawkinson</u> ADDRESS <u>1756 Park Rd.</u>   |  | 24a. REC'D BY REGISTRAR DATE <u>JAN 7 '60</u>  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>                   |





0859

CERTIFICATE OF DEATH

00831

Reg. Dist. No.

|   |                           |  |                                   |   |   |  |  |
|---|---------------------------|--|-----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                           |  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Id.</u> b. COUNTY <u>Mont.</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>  |                           |  |                                   | c. LENGTH OF STAY IN 1b <u>1 month</u>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens JAN.</u>   |                           |  |                                   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>LENA</u> Middle <u>ELLEN</u> Last <u>Cobb</u>   |                           |  |                                   | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>19</u> Year <u>1960</u>   |   |  |  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-19-1894</u> | 9. AGE (In years last birthday) <u>65</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>65</u> Days <u>65</u> Hours <u>65</u> Min. <u>65</u> | IF UNDER 24 HRS.<br>Months <u>65</u> Days <u>65</u> Hours <u>65</u> Min. <u>65</u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>  |                           |  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country) <u>New York</u>                          |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>  |                           |  |                                   | 13. FATHER'S NAME <u>NATHAN GRANT</u>   |   |  |  |
| 14. MOTHER'S MAIDEN NAME <u>MARGARET FITZPATRICK</u>  |                           |  |                                   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)                 |   |  |  |
| 16. SOCIAL SECURITY NO. <u>563-48-4474-A</u>  |                           |  |                                   | INFORMANT Address <u>Mr. E. B. Cobb, 3816 Littleton St.</u>   |   |  |  |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>170X</u> DUE TO <u>Cancer of the Breast with Metastasis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Silver Spring, Md.</u> DUE TO <u>Interval between onset and death Jan 1958 - Jan 1960</u><br>(c) <u>Interval between onset and death Jan 1958 - Jan 1960</u> |                           |  |                                   | 18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |  |                                   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           |  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u>19</u>  |                           |  |                                   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                              |   |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           |  |                                   | 20f. (City or town) (County) (State)  |   |  |  |
| 21. I certify that I attended the deceased from <u>12-17</u> , 19 <u>59</u> , to <u>Jan 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 17</u> , 19 <u>60</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.  |                           |  |                                   |   |   |  |  |
| ACTUAL SIGNATURE <u>Michael R. Dobridge</u>   |                           |  |                                   | ADDRESS (Street, city or town, state) <u>10620 Georgia Ave, Silver Spring, Md</u>   |   |  |  |
| PHYSICIAN'S NAME (Type) <u>MICHAEL R. DOBRIDGE</u>  |                           |  |                                   | DATE SIGNED <u>Jan 20 '60</u>   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>  |                           |  |                                   | 22b. DATE THEREOF <u>1/22/60</u>  |   |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>GLOVERSVILLE CEMETERY</u>   |                           |  |                                   | 22d. LOCATION (City, town, or county) (State) <u>GLOVERSVILLE, NEW YORK</u>   |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>  |                           |  |                                   | 24a. REC'D BY REGISTRAR DATE <u>JAN 20 '60</u>  |   |  |  |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>   |                           |  |                                   |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PROFESSOR

CERTIFICATE OF DEATH

Reg. Dist. No.

00832

|   |  |                                  |  |  |  |  |  |
|---|--|----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>   |  |                                  |  | c. LENGTH OF STAY IN 1b <b>1 HR. 25 MIN.</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>  |  |                                  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>AZALIA BEATRICE COLES</b>   |  |                                  |  | 4. DATE OF DEATH Month Day Year<br><b>JANUARY 12 19 60</b>   |  |  |  |
| 5. SEX <b>FEMALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>    |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>2/21/95</b>  |  |
| 9. AGE (In years last birthday) <b>64</b> yrs.  |  | IF UNDER 1 YEAR Months Days      |  | IF UNDER 24 HRS. Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>  |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>          |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |                                  |  |  |  |  |  |
| 13. FATHER'S NAME <b>JOSEPH YORK</b>  |  |                                  |  | 14. MOTHER'S MAIDEN NAME <b>LAURA DENNY</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |                                  |  | 16. SOCIAL SECURITY NO. <b>Unknown</b>   |  |  |  |
| 17. INFORMANT <b>HOSPITAL RECORDS</b>   |  |                                  |  | Address <b>OLNEY, MARYLAND</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Coronary sclerosis -</b><br>(c) <b>Carcinoma of left breast with metastasis to the lungs - Bronchopneumonia</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>metastasis to the lungs - Bronchopneumonia</b> |  |                                  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                                  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |                                  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |                                  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <b>1954</b> , 19____, to <b>Jan 12, 1960</b> that I last saw the deceased alive on <b>Jan 12</b> , 19____, and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>GAITHERSBURG, MARYLAND</b><br>DATE SIGNED <b>1-13-60</b>   |  |                                  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>J. Schumacher</b> M.D.  |  |                                  |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>J. SCHUMACHER, M. D.</b>   |  |                                  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>1-15-60</b> |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Robert A. Pumphrey, Bethesda, Maryland</b>  |  |                                  |  | 24a. REC'D BY REGISTRAR <b>JAN 15 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>                        |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0899 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00833

Reg. Dist. No.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u><br>c. LENGTH OF STAY IN 1b <u>7 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery County General Hospital</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u><br>d. STREET ADDRESS _____<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First <u>Maude</u> Middle _____ Last <u>Colley</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>1</u> Day <u>17</u> Year <u>1960</u>   |  | <b>5. SEX</b> <u>Female</u><br><b>6. COLOR OR RACE</b> <u>White</u><br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>5/14/69</u><br><b>9. AGE</b> (In years last birthday) <u>90</u> yrs.  |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u><br><b>11. BIRTHPLACE</b> (State or foreign country) <u>Pennsylvania</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>  |  | <b>13. FATHER'S NAME</b> <u>Layton Runyon</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Brugler</u>   |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u><br><b>16. SOCIAL SECURITY NO.</b> <u>NONE</u><br><b>17. INFORMANT</b> <u>Hospital Records, Olney, Maryland</u>   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute pneumonia</u><br><u>626X</u> DUE TO _____<br>Conditions, if any, which gave rise to immediate cause (b) <u>Rupture of pelvic ulcer</u><br>(c), stating the underlying cause last. DUE TO _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left hip 1-10-60</u> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u><br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Fell on floor at home</u><br><b>20c. TIME OF INJURY</b> Month, Day, Year <u>1 10 1960</u><br>Hour <u>7:30</u> o. m. <u>PM</u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u><br><b>20f. (City or town)</b> <u>Sandy Spring, Montg. Md.</u> (County) _____ (State) _____       |  | <b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> M.D.<br><b>EXAMINER'S NAME</b> (Type) <u>Frank J. Broschart</u>  |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> |  | <b>DATE SIGNED</b><br><u>Jan. 18, 1960</u>  |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>CREMATION</u><br><b>22b. DATE THEREOF</b> <u>JAN. 19, 1960</u><br><b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln</u><br><b>22d. LOCATION</b> (City, town, or county) <u>Prince George</u> (State) <u>Md.</u>   |  | <b>24a. REC'D BY REGISTRAR</b> <u>JAN 22 60</u><br><b>DATE</b> _____   |  | <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Parnell</u>  |  |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## DEPT. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                                     |  |                                |  |
|-------------------------------------|--|--------------------------------|--|
| NAME OF DECEASED<br>[REDACTED]      |  | SEX<br>[REDACTED]              |  |
| AGE<br>[REDACTED]                   |  | RACE<br>[REDACTED]             |  |
| DATE OF DEATH<br>[REDACTED]         |  | TIME OF DEATH<br>[REDACTED]    |  |
| PLACE OF DEATH<br>[REDACTED]        |  | CITY OR TOWNSHIP<br>[REDACTED] |  |
| COUNTY<br>[REDACTED]                |  | STATE<br>[REDACTED]            |  |
| OCCUPATION<br>[REDACTED]            |  |                                |  |
| CAUSE OF DEATH<br>[REDACTED]        |  |                                |  |
| MANNER OF DEATH<br>[REDACTED]       |  |                                |  |
| SIGNATURE OF EXAMINER<br>[REDACTED] |  |                                |  |
| DATE<br>[REDACTED]                  |  |                                |  |



## CERTIFICATE OF DEATH

Reg. Dist. No.

00834

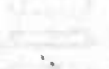
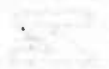
|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring 56</i>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. &amp; Hospital</i>  |                               | d. STREET ADDRESS <i>9604 Evergreen St.</i>  |   |
| 3. NAME OF DECEASED (Type or print) First <i>Merton</i> Middle <i>Eugene</i> Last <i>Collins</i>  |                               | 4. DATE OF DEATH Month <i>Jan.</i> Day <i>7</i> Year <i>1960</i>   |   |
| 5. SEX <i>Male</i>  | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>5-16-07</i>         |
| 9. AGE (In years lost birthday) <i>52</i> yrs.  |                               | IF UNDER 1 YEAR Months Days Hours Min.   | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Passenger Representative B &amp; O. Railroad</i>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <i>District of Columbia</i>  |   |
| 11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>   |                               | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |   |
| 13. FATHER'S NAME <i>Walter Collins</i>   |                               | 14. MOTHER'S MAIDEN NAME <i>Elsie Lang</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>   |                               | 16. SOCIAL SECURITY NO. <i>705-09-0590</i>   |   |
| 17. INFORMANT <i>W.S.H. Records</i>   |                               | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Anterior Myocardial Infarction</i><br>420.1<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumonia right lower lobe</i><br>DUE TO (c) <i>Congestive Heart Failure</i><br>DUE TO |                               | INTERVAL BETWEEN ONSET AND DEATH<br><i>13 days</i><br><i>5 days</i><br><i>5 days</i>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <i>Dec 26</i> , 19 <i>59</i> , to <i>Jan 7</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Jan 7</i> , 19 <i>60</i> , and that death occurred at <i>10:32 AM</i> , from the causes and on the date stated above.  |                               |  |   |
| ACTUAL SIGNATURE <i>Philip E. Jones</i>   |                               | ADDRESS (Street, city or town, state) <i>918 Ellsworth Drive</i>   |   |
| PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>  |                               | DATE SIGNED <i>Silver Spring, Md.</i>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>   |                               | 22b. DATE THEREOF <i>1/9/60</i>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <i>PARKLAWN CEMETERY</i>   |                               | 22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MD.</i>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Zucka</i>  |                               | ADDRESS <i>SILVER SPRING, MD.</i>  |   |
| 24a. REC'D BY REGISTRAR <i>JAN 8 '60</i>  |                               | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEPOSIT

DATE



Pay to the order of \_\_\_\_\_  
the sum of \_\_\_\_\_ Dollars  
for deposit only  
and to credit to the account of \_\_\_\_\_  
of \_\_\_\_\_  
this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_  
at \_\_\_\_\_  
Standard International Banking Corporation  
President \_\_\_\_\_  
Cashier \_\_\_\_\_

with 30 days

STANDARD INTERNATIONAL BANKING CORPORATION

NEW YORK, N. Y.

0804

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>District of Columbia</b><br>b. COUNTY <b>Washington</b> <b>47X-3</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION<br><b>Fairland Nursing Home</b>   |   | d. STREET ADDRESS<br><b>408 Rittenhouse St., N.W.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MAY</b> Middle <b>I.</b> Last <b>COLWELL</b>   |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>12</b> Year <b>19 60</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                  | 8. DATE OF BIRTH<br><b>5/1/85</b>                                     |
| 9. AGE (In years last birthday) yrs. <b>74</b>   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Albert Fahrney</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Zeller</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>578-10-8435D</b>  |   |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Insufficiency</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerotic heart disease</b><br>lying cause lost. (c) <b>Unknown</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Colostomy - post operative intestinal obstruction cause undetermined</b>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that I attended the deceased from <b>July 26, 1954</b> to <b>Jan 12, 1960</b> , that I last saw the deceased alive on <b>December 26, 1959</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.   |   |   |   |
| ACTUAL SIGNATURE <b>Aaron H. Traum</b>   |   | ADDRESS (Street, city or town, state) <b>837 Georgia Ave Silver Spring, Md 11/260</b>   |   |
| PHYSICIAN'S NAME (Type) <b>AARON H. TRAUM</b>  |   | DATE SIGNED <b>8237 Georgia Ave. Silver Spring, Md</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>1/15/60</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Suitland, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph Gawler's Sons, Inc. Wash., D.C.</b>  |   | 24a. REC'D BY REGISTRAR<br><b>1756 Pa. Ave.</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Traum</b>                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be filled with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

City of Columbia

Washington

Age at death

Male

Female

House No.

Street Name

Year of birth

*George Washington*  
*Washington, D.C.*

*George Washington*  
*Washington, D.C.*

*George Washington*  
*Washington, D.C.*

*George Washington*  
*Washington, D.C.*

*George Washington*  
*Washington, D.C.*

*George Washington*  
*Washington, D.C.*

*George Washington*  
*Washington, D.C.*

*George Washington*  
*Washington, D.C.*

## CERTIFICATE OF DEATH

Reg. Dist. No.

00836

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OLNEY</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>8 DAYS</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC.</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| e. STREET ADDRESS<br><b>LAYHILL ROAD</b>   |  |   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ELIZABETH</b> Middle <b>LENA</b> Last <b>CONSER</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>8</b> Year <b>19 60</b>  |  |  |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8/9/81</b>                            |  |
| 9. AGE (In years lost birthday)<br><b>78</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>28</b> Days <b>78</b> Hours <b>78</b> Min. |  | IF UNDER 24 HRS.<br>Months <b>28</b> Days <b>78</b> Hours <b>78</b> Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Franciscus Knell</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ANNIE REGER</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  |  |  |
| 17. INFORMANT<br><b>HOSPITAL RECORDS</b>   |  |   |  | Address<br><b>OLNEY, MARYLAND</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b><br><b>491X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Acute Tracheobronchitis.</b><br>(c) <b>Diabetic Coma and Uremia.</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |  |  |
| 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>54</b> , to <b>Jan</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/8</b> , 19 <b>60</b> , and that death occurred at <b>4:00</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>SANDY SPRING, MARYLAND</b> DATE SIGNED <b>1/9/60</b><br>ACTUAL SIGNATURE <b>A. D. Bonifant</b> M.D. <b>Sandy Spring Md 1/9/60</b><br>PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M. D.</b> <b>SANDY SPRING, MARYLAND</b>   |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |   |  | 22b. DATE THEREOF<br><b>1/12/60</b>  |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Meadow Ridge Mem. Pk. Cemetery</b>  |  |   |  | 22d. LOCATION (City, town, or county) (State)<br><b>near Dorsey, Maryland</b>  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PUMPHREY, INC.</b><br><b>Raymond W. Ziska</b>   |  |   |  | ADDRESS<br><b>SILVER SPRING, MD.</b>   |  |  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 12 '60</b>  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>   |  |  |  |

TO HOSPITAL OR AT HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

PROFESSION

RELIGION

DATE OF INTERVIEW

INTERVIEWER

DATE OF DEATH

PLACE OF DEATH

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF INTERVIEW

INTERVIEWER

DATE OF DEATH

PLACE OF DEATH



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
5M 2/57

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |  |   |                                      |  |  |  |   |  |  | 00837  |
|---|--|---|--------------------------------------|--|--|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |                                      |  |  |  |   |  |  | Reg. Dist. No.   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>0805</u> MARYLAND   |  |   |                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Montg</u> |  |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>   |  |   | c. LENGTH OF STAY IN 1b <u>2 yrs</u> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>                           |  |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2204 Colston Dr</u>   |  |   |                                      |  | d. STREET ADDRESS <u>2204 Colston Dr</u>   |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 3. NAME OF DECEASED (Type or print) <u>George Washington Costin</u>   |  |   | First Middle Last                    |  | 4. DATE OF DEATH <u>Jan 17 1960</u>  |  | Month Day Year                                    |  |  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>white</u>   |                                      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 8. DATE OF BIRTH <u>Oct 13-1886</u>  |   | 9. AGE (in years last birthday) <u>73</u> yrs.   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                      | 11. BIRTHPLACE (State or foreign country) <u>md</u>  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>        |  |  |  |
| 13. FATHER'S NAME <u>Thomas W. Costin</u>   |  |   |                                      |  | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>   |  | 16. SOCIAL SECURITY NO. <u>WW I</u>   |                                      | 17. INFORMANT <u>Thomas W. Costin 2d</u> Address <u>3522 Abby Ln Jacksonville Fla.</u>   |  |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br><u>929.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Drowning</u><br>DUE TO (c) <u>Aurricular fibrillation</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bathroom</u> |  |   |                                      |  |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |  |   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead - with head in bath tub full of running water</u> |  |  |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>1-17-60</u>  |  | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>   |  | 20f. (City or town) <u>Silver Spring</u> (County) <u>Montg.</u> (State) <u>Md.</u> |   |  |  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |   |                                      |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.   |  |   |                                      |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |  | DATE SIGNED  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>  |  |   |                                      |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |  |  |
|   |  |   |                                      |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jun 18 1960</u>   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>1-20-60</u>  |                                      | 22c. NAME OF CEMETERY OR CREMATORY <u>Nash Creek Cem</u>   |  | 22d. LOCATION (City, town, or county) <u>Washington DC</u> (State)                 |   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u> ADDRESS <u>4812 La Ave NW</u>   |  |   |                                      |  | 24a. REC'D BY REGISTRAR <u>JAN 22 '60</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>C. J. S. Funder</u> |  |  |  |

FOR STATE  
HEALTH DEPT.

0803

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. NAME OF DECEASED<br><i>John Doe</i>                                   |  | 2. SEX<br><i>Male</i>                                       |  | 3. AGE<br><i>45</i>                                     |  |
| 4. OCCUPATION<br><i>Teacher</i>  |  | 5. MARITAL STATUS<br><i>Married</i>                         |  | 6. PLACE OF BIRTH<br><i>USA</i>                         |  |
| 7. DATE OF DEATH<br><i>10/15/1968</i>                                    |  | 8. TIME OF DEATH<br><i>10:00 AM</i>                         |  | 9. PLACE OF DEATH<br><i>Home</i>                        |  |
| 10. CAUSE OF DEATH<br><i>Myocardial Infarction</i>                       |  | 11. MANNER OF DEATH<br><i>Natural</i>                       |  | 12. SIGNATURE OF EXAMINER<br><i>[Signature]</i>         |  |
| 13. SIGNATURE OF DECEASED<br><i>[Signature]</i>                          |  | 14. SIGNATURE OF WITNESS<br><i>[Signature]</i>              |  | 15. SIGNATURE OF PHYSICIAN<br><i>[Signature]</i>        |  |
| 16. SIGNATURE OF FUNERAL HOME<br><i>[Signature]</i>                      |  | 17. SIGNATURE OF CORONER<br><i>[Signature]</i>              |  | 18. SIGNATURE OF JURY<br><i>[Signature]</i>             |  |
| 19. SIGNATURE OF DISTRICT ATTORNEY<br><i>[Signature]</i>                 |  | 20. SIGNATURE OF CLERK<br><i>[Signature]</i>                |  | 21. SIGNATURE OF NOTARY<br><i>[Signature]</i>           |  |
| 22. SIGNATURE OF JUDGE<br><i>[Signature]</i>                             |  | 23. SIGNATURE OF SHERIFF<br><i>[Signature]</i>              |  | 24. SIGNATURE OF DEPUTY SHERIFF<br><i>[Signature]</i>   |  |
| 25. SIGNATURE OF DEPUTY CLERK<br><i>[Signature]</i>                      |  | 26. SIGNATURE OF DEPUTY NOTARY<br><i>[Signature]</i>        |  | 27. SIGNATURE OF DEPUTY JURY<br><i>[Signature]</i>      |  |
| 28. SIGNATURE OF DEPUTY DISTRICT ATTORNEY<br><i>[Signature]</i>          |  | 29. SIGNATURE OF DEPUTY CORONER<br><i>[Signature]</i>       |  | 30. SIGNATURE OF DEPUTY PHYSICIAN<br><i>[Signature]</i> |  |
| 31. SIGNATURE OF DEPUTY FUNERAL HOME<br><i>[Signature]</i>               |  | 32. SIGNATURE OF DEPUTY WITNESS<br><i>[Signature]</i>       |  | 33. SIGNATURE OF DEPUTY EXAMINER<br><i>[Signature]</i>  |  |
| 34. SIGNATURE OF DEPUTY STATE DEPARTMENT OF HEALTH<br><i>[Signature]</i> |  | 35. SIGNATURE OF DEPUTY BALTIMORE, MD<br><i>[Signature]</i> |  | 36. SIGNATURE OF DEPUTY MARYLAND<br><i>[Signature]</i>  |  |

0901

00838

**CERTIFICATE OF DEATH**

Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Kentucky</b> <b>✓</b><br>b. COUNTY                     |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>4 days</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Estill</b> Middle <b>Douglas</b> Last <b>Grace</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>15</b> Year <b>19 60</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>September 18, 1911</b>                             |  |
| 9. AGE (In years lost birthday)<br><b>48 yrs.</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mechanic</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Kentucky</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                           |  |
| 13. FATHER'S NAME<br><b>Willie Grace</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Nellie Patrick</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>402-16-7557</b>   |  |   |  |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage</b><br><b>443X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>443X</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>years</b>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                      |  |
| 21. I certify that I attended the deceased from <b>January 11, 19 60</b> to <b>January 15, 19 60</b> that I last saw the deceased alive on <b>January 15, 1960</b> and that death occurred at <b>3:35 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br>DATE SIGNED <b>1/15/60</b>   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Victor W. Sidel</b>   |  |   |  | M.D. <b>The Clinical Center</b>   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Victor W. Sidel, M.D.</b>  |  |   |  | <b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF<br><b>1/16/60</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Prestonsburg, Ky.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. W. Chambers Co. 1400 Chapin St. N.W. Wash., D.C.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 21 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kinn</b>                       |  |

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

January 15

January 15

January 15

January 15

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U. S. A.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0902 CERTIFICATE OF DEATH

Reg. Dist. No.

00839

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>District of Columbia</b> ✓                             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Potomac</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D. C. 47X-3</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Ropine Nursing Home</b>  |   | d. STREET ADDRESS<br><b>1650 Harvard St. N. W.</b>  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ARTHUR</b> Middle <b>A</b> Last <b>DANZI</b>  |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>7</b> Year <b>1960</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov 10, 1899</b>                                     |
| 9. AGE (In years last birthday)<br><b>60</b> yrs.   |   | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>27</b>   | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Owner - Restaurant</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>                |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U S</b>  |   |   |   |
| 13. FATHER'S NAME<br><b>Anthony Danzi</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Lillie Delmonico</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |   | 16. SOCIAL SECURITY NO.<br><b>577-32-2201</b>   |   |
| (If yes, give war or dates of service)<br><b>WW 2</b>   |   | INFORMANT<br><b>Richard A. Danzi-brother-Burbank Dr.</b>  |   |
| Address <b>Potomac, Md</b>  |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>332X</b> IMMEDIATE CAUSE (a) <b>Cerebral thrombosis (massive)</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arterio-sclerosis (cerebral) several years.</b><br>DUE TO<br>(c) <b>Thrombosis left Int. Caudal Artery</b><br>2 years |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>Feb 23, 1958</b> to <b>Jan 7, 1960</b> , that I last saw the deceased alive on <b>Jan 6, 1960</b> , and that death occurred at <b>6:45 P. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Frederic D. Chapman</b> M.D. <b>Jan 8 / 60</b>   |   |   |   |
| ACTUAL SIGNATURE  |   |   |   |
| PHYSICIAN'S NAME (Type) <b>Frederic D. Chapman, M.D. 1150 Conn. Ave. N. W. Wash. D. C.</b>  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>1-12-60</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Nat'l Cem.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 '60</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Knorr</b>                        |

1. Page 4

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

0905 CERTIFICATE OF BIRTH

State of Maryland

Light of Birth

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00840

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>106 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b> |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>West Virginia</b><br>b. COUNTY<br><b>Charleston</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>1108 Washington Street, East</b><br>d. STREET ADDRESS<br><b>85 X - 3</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Helen</b> Middle <b>Elizabeth</b> Last <b>Daugherty</b>   |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>7</b> Year <b>1960</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>June 23, 1914</b>                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Practical Nurse</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Nursing</b>  | 9. AGE (In years last birthday)<br><b>45</b> yrs.                         |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   |
| 13. FATHER'S NAME<br><b>William Jarrels</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Hartman</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>236-50-7201</b>  |   |
| 17. INFORMATION<br><b>The Medical Record</b>   |   | Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myelogenous Leukemia</b><br>204.3<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO (c) _____                    |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years 3 Mo</b>                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) _____ (County) _____ (State) _____                    |
| 21. I certify that I attended the deceased from <b>September 23, 1959</b> to <b>January 7, 1960</b> , that I last saw the deceased alive on <b>January 7, 1960</b> , and that death occurred at <b>10:30p</b> AM, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>1-8-60</b> |   |  |   |
| ACTUAL SIGNATURE _____ M.D.<br>PHYSICIAN'S NAME (Type) <b>JERRY S. TRIER, M.D.</b>   |   | <b>The Clinical Center</b><br><b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  | 22b. DATE THEREOF<br><b>Jan. 8th</b>  | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State)<br><b>Charleston W. Va.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>C. P. Jones</b> ADDRESS <b>Washington, D.C.</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 '60</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                                      |  |   |  |
|--------------------------------------|--|---|--|
| Date of Death<br>1900                |  | Place of Birth<br>Maryland                  |  |
| Name of Deceased<br>John A. Smith    |  | Age<br>35                                   |  |
| Date of Death<br>1900                |  | Place of Death<br>Baltimore, Maryland       |  |
| Name of Physician<br>Dr. J. H. Jones |  | Name of Medical Examiner<br>Dr. J. H. Jones |  |
| Cause of Death<br>Heart Disease      |  | Manner of Death<br>Natural                  |  |
| Date of Death<br>1900                |  | Place of Death<br>Baltimore, Maryland       |  |
| Name of Physician<br>Dr. J. H. Jones |  | Name of Medical Examiner<br>Dr. J. H. Jones |  |
| Cause of Death<br>Heart Disease      |  | Manner of Death<br>Natural                  |  |
| Date of Death<br>1900                |  | Place of Death<br>Baltimore, Maryland       |  |
| Name of Physician<br>Dr. J. H. Jones |  | Name of Medical Examiner<br>Dr. J. H. Jones |  |
| Cause of Death<br>Heart Disease      |  | Manner of Death<br>Natural                  |  |

## CERTIFICATE OF DEATH

Reg. Dist. No.

00841

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>D. C.</b> b. COUNTY                                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>13 hrs.</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Suburban Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>James</b> Middle <b>Clifton</b> Last <b>Davis</b>  |                                  | 4. DATE OF DEATH<br>Month <b>1/</b> Day <b>11</b> Year <b>1960</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/2/01</b>                                  |
| 9. AGE (In years last birthday)<br><b>58</b> yrs.  |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Hollywood, Md.</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  | 13. FATHER'S NAME<br><b>Louis Charles Davis</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Sarah Wilkinson</b>   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                   |  |
| 16. SOCIAL SECURITY NO.<br><b>579-03-0129</b>  |                                  | 17. INFORMANT<br><b>Wife (same as above)</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction, multiple, severe</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis, severe</b><br>DUE TO<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs</b><br><b>9 yrs</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Myocardial Infarction 1951 (Aug 15)</b>  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. _____ p. m. _____ 19____  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>51</b> , to <b>Jan 11</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 11</b> , 19 <b>60</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.   |                                  |  |  |
| ACTUAL SIGNATURE <b>Stewart Clapp</b>  |                                  | ADDRESS (Street, city or town, state) <b>3921 Ingomar St Wash 15 D.C.</b>  |  |
| PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>   |                                  | DATE SIGNED <b>1/11/60</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>1/14/60</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>MT. OLIVET CEMETERY</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>WASHINGTON, D.C.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PUMPHREY, INC.</b><br><b>Raymond A. Ziska</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>JAN 13 '60</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>  |                                  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0850

00842

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>3939 Newdale Road</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>KATE M. DAVIS</b>   |                                  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>13</b> , Year <b>1960</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 9, 1864</b>                  |
| 9. AGE (In years last birthday)<br><b>95</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <b>9</b> Days <b>4</b> Hours <b></b> Min. <b></b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Tenn.</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  | 13. FATHER'S NAME<br><b>Elbert Maloney</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary I. ?</b>   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |   |
| 16. SOCIAL SECURITY NO.<br><b>None</b>   |                                  | 17. INFORMANT<br><b>Grandson</b>  |   |
| 18. ADDRESS<br><b>Raymond J. Consley, Valley Dr., Rockville, Md.</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Central thrombosis and hemorrhage -</b><br><b>332x</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Generalized arteriosclerosis -</b><br>DUE TO<br>(c) <b></b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>30 years</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 21. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 22c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 22d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 22f. (City or town) (County) (State)  |   |
| 23. I certify that (I) (this hospital) attended the deceased from <b>Jan 11</b> , 19 <b>54</b> , to <b>Jan 13</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Jan 13</b> , 19 <b>60</b> , and that death occurred at <b>7:40 P.M.</b> , from the causes and on the date stated above.   |                                  |   |   |
| 24. SIGNATURE<br><b>William B. Walsh M.D.</b>  |                                  | 25. DATE SIGNED<br><b>Jan 13 1960</b>   |   |
| 26. PHYSICIAN'S NAME (Type)<br><b>WILLIAM B. WALSH M.D.</b>  |                                  | 27. ADDRESS<br><b>1835 Eye St N.W. - WASH. D.C.</b>   |   |
| 28. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 29. DATE THEREOF<br><b>1-15-60</b>  |   |
| 30. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>  |                                  | 31. LOCATION (City, town, or county) (State)<br><b>Rockville, Maryland</b>  |   |
| 32. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>  |                                  | 33. REC'D BY REGISTRAR<br>DATE <b>JAN 15 '60</b>  |   |
| 34. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |                                  | 35. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |   |

24



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0806 CERTIFICATE OF DEATH

00843

Reg. Dist. No.

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Canada</u> b. COUNTY <u>✓</u>                       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montreal</u> 90X-3   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairland Nursing Home</u>   |   | d. STREET ADDRESS <u>211 Mt. Royal Ave.</u>  |   |
| 3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Dec</u> Last <u>Kelbaum</u>   |   | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>12</u> Year <u>1960</u>  |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1878</u>                                    |
| 9. AGE (In years last birthday) <u>82</u> yrs.  |   | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>  | IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>  | 11. BIRTHPLACE (State or foreign country) <u>Russia</u>         |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |   | 13. FATHER'S NAME <u>Itzik Malamedick</u>  |   |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>                            |   |
| 16. SOCIAL SECURITY NO. <u>  </u>   |   | 17. INFORMANT Address <u>Isadore Deckelbaum-5601-1st St. N.E.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASPIRATION OF VOMITUS</u><br>450.0 DUE TO <u>INANITION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u><br>DUE TO <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> |   |  |   |
| INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u><br><u>6 months</u><br><u>years</u>  |   |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                            |
| 21. I certify that I attended the deceased from <u>August</u> , 19 <u>59</u> , to <u>1-12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-12</u> , 19 <u>60</u> , and that death occurred at <u>7:00</u> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>931 PERSHING DRIVE</u> DATE SIGNED <u>1-12-60</u><br>ACTUAL SIGNATURE <u>Jason Geiger</u> M.D. <u>  </u><br>PHYSICIAN'S NAME (Type) <u>Jason Geiger</u> <u>SILVER SPRING, MD.</u>    |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>Jan. 14, 1960</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>ELES AVETARAD CEM.</u>   | 22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dancansky &amp; Sons</u> ADDRESS <u>3501-14th St. N.W. Wash. D.C.</u>  |   | 24a. REC'D BY REGISTRAR <u>  </u> DATE <u>JAN 15 '60</u>   | 24b. REGISTRAR'S SIGNATURE <u>  </u>                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

00844

0860

|  |                                  |  |                                      |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>--</b> b. COUNTY <b>--</b>                          |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1 week</b>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Carroll Hall Sanitarium</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>George</b> Middle <b>H.</b> Last <b>Dierkoph</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>1</b> Year <b>1960</b>  |                                      |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4/19/1870</b> |
| 9. AGE (In years last birthday) yrs.<br><b>89</b>  |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>P.E. Power Co.</b>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                      |
| 13. FATHER'S NAME<br><b>Franz Dierkoph</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Louise Reiter</b>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |                                  | 16. SOCIAL SECURITY NO. <b>no</b>  |                                      |
| 17. INFORMANT<br><b>Henry K. Dierkoph</b>  |                                  | Address<br><b>5722 Bradley Blvd. Bethesda, Md.</b>   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>DIFFUSE BRONCHOPNEUMONIA</b><br>332X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRAL THROMBOSIS</b><br>DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>72 HRS</b><br><b>96 HRS</b><br><b>UNDETERMINED.</b> |                                  |  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <b>NOV. 30, 1959</b> to <b>JAN. 1, 1960</b> , that I last saw the deceased alive on <b>JAN. 1, 1960</b> , and that death occurred at <b>10:28 P.M.</b> from the causes and on the date stated above.   |                                  |  |                                      |
| ACTUAL SIGNATURE<br><b>John H. Trosky</b>  |                                  | ADDRESS (Street, city or town, state).<br><b>7720 WISCONSIN AVE BETHESDA MD.</b>   |                                      |
| PHYSICIAN'S NAME (Type)<br><b>John H. Trosky, M.D.</b>   |                                  | DATE SIGNED<br><b>1/4/60</b>   |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>1/4/1960</b>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D.C.</b>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Co.</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>JAN 4 '60</b>  |                                      |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                  |  |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0860

John Henry

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Washington, D.C.

1 year

1901 Washington, D.C.

George

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Jan. 1 1900

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1. P. Lower Co.

Washington, D.C.

From District

John's Mother

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Henry E. District - 1st Sunday

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## CERTIFICATE OF DEATH

Reg. Dist. No.

00845

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|--|--|---------------------------------------|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery County</u> MARYLAND   |  |                                       |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  |                                       |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 17</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp.</u>  |  |                                       |  | d. STREET ADDRESS <u>7123 Sycamore Ave.</u>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Geraldine Cecelia Duncan</u>  |  |                                       |  | 4. DATE OF DEATH <u>Jan. 15 1960</u>   |  |   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>         |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Aug 7, 1904</u>   |  |
| 9. AGE (In years last birthday) <u>55</u> yrs.   |  | IF UNDER 1 YEAR <u>35</u> Months      |  | IF UNDER 24 HRS. <u>15</u> Days  |  | IF UNDER 24 HRS. <u>15</u> Hours  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Claim Adjuster</u>  |  |                                       |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, DC.</u>                    |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |                                       |  | 13. FATHER'S NAME <u>Julius Backenheimer</u>   |  |   |  |
| 14. MOTHER'S MAIDEN NAME <u>Bertha M. Burke</u>  |  |                                       |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)                                      |  |   |  |
| 16. SOCIAL SECURITY NO. <u>Mrs. Laney - 7123 Sycamore Ave. Hyattsville, Md.</u>  |  |                                       |  | 17. INFORMANT <u>Takoma Park Police, Md.</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease.</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>1 mon.</u> |  |                                       |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                       |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Hour o. m. _____<br>p. m. _____   |  | Month, Day, Year<br>19 _____          |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)              |  |
| 20f. (City or town)  |  | (County)                              |  | (State)  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21. I certify that I attended the deceased from <u>1954</u> to <u>Jan 11, 1960</u> , that I last saw the deceased alive on <u>Jan 11, 1960</u> , and that death occurred at <u>undeter.</u> ADDRESS (Street, city or town, state) <u>6216 N.H. Ave N.E.</u> DATE SIGNED <u>1/15/60</u>   |  |                                       |  |  |  |   |  |
| ACTUAL SIGNATURE <u>William F. Simpson, Jr.</u> M.D.   |  |                                       |  | PHYSICIAN'S NAME (Type) <u>William F. Simpson Jr.</u> <u>Washington, D.C.</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF <u>Jan 19, 1960</u> |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Mount Alto Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>                |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Francis</u> ADDRESS <u>254 Carroll St N.W.</u>   |  |                                       |  | 24a. REC'D BY REGISTRAR DATE <u>JAN 19 1960</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Francis</u>                                 |  |

Certificate signed at direction of coroner's office.

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first part of the document is a letter from the author to the editor, dated 10/10/1910. The letter is signed "Yours truly, [illegible]" and is addressed to "The Editor, [illegible]". The letter discusses the author's recent work on the history of the [illegible] and mentions that the author has been working on this project for some time. The author also mentions that the work is now complete and that the author is submitting it to the editor for consideration. The letter ends with a request for the editor to let the author know if the work is accepted for publication.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00846

|  |                                  |   |  |   |   |   |  |  |
|--|----------------------------------|---|--|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>0905</b> <b>MARYLAND</b>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |   |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  |   | c. LENGTH OF STAY IN Tb<br><b>2 1/2 days</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>58 Chevy Chase</b> |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Suburban Hospital</b>   |                                  |   |  | d. STREET ADDRESS<br><b>5325 Baltimore Ave.</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>D.</b> Last <b>Dunn</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>2</b> Year <b>1960</b>  |   |   |  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 23 1977</b>  |   | 9. AGE (In years last birthday)<br><b>82 yrs.</b>   | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b>                       | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Illinois</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |  |
| 13. FATHER'S NAME<br><b>GeorgBivers</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Ward</b>   |   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br>-----  |  | 17. INFORMANT<br><b>Helen Dunn L ynch (daughter) above</b>  |   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Subdural hematoma, Lt. fronto-parietal</b><br>DUE TO (c) -----  |                                  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><br><b>4 days</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----  |                                  |   |  |   |   |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Found in coma on bed room floor at home</b>              |  |   |   |   |  |  |
| 20c. TIME OF INJURY<br>Hour <b>?</b> o. m. <b>12/30</b> 19 <b>59</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>home</b>   |   | 20f. (City or town) (County) (State)<br><b>Chevy Chase Montg. Md.</b>                             |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                  |   |  |   |   |   |  |  |
| ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.  |                                  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   |  |  |
| EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>   |                                  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |  |  |
|  |                                  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>1/5/60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood, C.M.</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Cleveland Ohio</b>                            |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Cheng Chase Funeral Home</b>  |                                  |   |  | ADDRESS<br><b>5103 Winton Road, D.C.</b>  |   | 24a. REC'D BY REGISTRAR<br><b>Jan 7 '60</b>   |  |  |
|  |                                  |   |  |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Harris</b>   |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## 0807 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |   |  |   |  |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b><br>c. LENGTH OF STAY IN 1b <b>7 years</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>761 Silver Spring Ave.</b>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b><br>d. STREET ADDRESS <b>761 Silver Spring Ave.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY</b> Middle <b>E.</b> Last <b>EMBREY</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>2</b> Year <b>1960</b>   |  |   |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/19/80</b>                | 9. AGE (In years last birthday)<br><b>79</b> yrs.   | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HRS.<br>Hours _____ Min. _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOMEMAKER</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>SHAKE HOLMES</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>VIRGINIA KEMPER</b> |   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |  | 17. INFORMANT<br><b>Mrs. Mabel Summers, 761 Silver Spring Ave.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema</b><br><b>446 X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Uremia</b><br>DUE TO (c) <b>Nephrosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral thrombosis due to arteriosclerosis</b> |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b><br><b>4 weeks</b><br><b>8 years</b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>—</b>  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. _____ p. m. _____ 19 _____  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>—</b>  |  | 20f. (City or town) _____ (County) _____ (State) _____                                |  |
| 21. I certify that I attended the deceased from <b>Oct</b> , 19 <b>59</b> , to <b>Jan</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 2</b> , 19 <b>60</b> , and that death occurred at <b>10:10 P.M.</b> , from the causes and on the date stated above.   |                                  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Ralph F. Patten</b>  |                                  | M.D. <b>8641 Colasville Rd</b>  |  | ADDRESS (Street, city or town, state)<br><b>Silver Spring Md</b>  |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>RALPH F. PATTEN</b>   |                                  | DATE SIGNED<br><b>Jan 3, 60</b>   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>1/6/60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Holly Baptist Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Remington, Virginia</b>           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PUMPHREY, INC.</b>   |                                  | ADDRESS<br><b>SILVER SPRING, MD.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>JAN 5 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>                                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 - may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0887 CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

ALBANY

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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0861  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00848

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> DISTRICT OF COLUMBIA                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>4 months</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D. C.</b> 47x-3 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Carroll Hall Sanitarium</b>   |                                  | d. STREET ADDRESS<br><b>3811 T Street, N. W.</b>  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>VIRGIE</b> Middle <b>HUGHES</b> Last <b>EVANS</b>  |                                  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>9</b> Year <b>1960</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 16, 1884</b>   |
| 9. AGE (In years last birthday)<br><b>75</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>23</b>   | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Missouri</b>   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  |   |  |
| 13. FATHER'S NAME<br><b>Virgil Hughes</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Lora Abingdon</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Son</b>  |                                  | Address<br><b>F. Hughes Evans-10220 Carroll Pl.-Kens.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b><br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c) DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Cerebral arterio-sclerosis</b> |                                  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs. +</b>   |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (the hospital) attended the deceased from <b>10 yrs. +</b> 19 <b>Jan 9</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Jan 6</b> 19 <b>60</b> , and that death occurred at <b>10:30</b> AM, from the causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><b>Karl Dortzbach</b>  |                                  | 22b. DATE SIGNED<br><b>1-9-60</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Karl Dortzbach, M.D.</b>  |                                  | 22d. ADDRESS<br><b>Washington Clinic, D. C.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>1-12-60</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JAN 14 '60</b>  |  |
| ADDRESS<br><b>Bethesda, Maryland</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles S. Hanna</b>   |  |

0881

CERTIFICATE OF DEATH

00-18

State of Maryland  
County of Prince George's  
I, the undersigned, Clerk of the Circuit Court for the County of Prince George's, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the said Court.  
Witness my hand and the seal of the said Court at the City of Alexandria, this 1st day of January, 1900.  
Clerk of the Circuit Court for the County of Prince George's

Attest:  
Notary Public for the State of Maryland  
My Commission Expires 1-1-00  
1-1-00



0906

## CERTIFICATE OF DEATH

00849

Reg. Dist. No.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>West Virginia</b> b. COUNTY <b>✓</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  |   | c. LENGTH OF STAY IN 1b<br><b>5 days</b> |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Great Cacapon</b> <b>95X-3</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |  |   |  | d. STREET ADDRESS<br><b>Box 27 Main Street</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Hobart</b> Middle <b>Franklin</b> Last <b>Farris</b>   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>24</b> Year <b>1960</b>                                   |  | 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>March 8, 1896</b>  |  | 9. AGE (In years lost birthday) <b>63</b> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>John W. Farris</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Minnie Tickerhoof</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Unascertainable</b>   |  | INFORMANT <b>The Medical Record</b> Address <b>Bethesda 14, Maryland</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO <b>Miliary dissemination, caseous pneumonia consistent with pulmonary tuberculosis, or disseminated histoplasmosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Acute and chronic peritonitis</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b><br><b>Unknown</b> |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>January 19, 1960</b> , to <b>January 24, 1960</b> , that I last saw the deceased alive on <b>January 24, 1960</b> , and that death occurred at <b>5:32 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>The Clinical Center Bethesda 14, Maryland</b> DATE SIGNED <b>1/25/60</b>  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Howard M. Kravetz, MD</b>  |  | PHYSICIAN'S NAME (Type) <b>Howard M. Kravetz, M.D.</b>  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Buried</b>   |  | 22b. DATE THEREOF<br><b>1-28-60</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Nebo</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Morgan Co. W. Va.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R. D. Pennington</b>  |  |   |  | ADDRESS<br><b>Bethesda, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>JAN 27 '60</b>  |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Evans</b>  |  |   |  |

For Sale by Public Auction

The Official Letter: Batonda 15-16

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1955-1956

moderately similar

John V. Forde

The National Record

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— Philip Anthony Mason, citizenship rights

Page 1 continued on next page, attached to preceding file

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acute and chronic hepatitis

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## 0907 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |  |   |   |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>(District of Columbia)</b> Pr. George |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>(Washington 21,) Hillcrest Heights, Md.</b>         |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |                                  |   | d. STREET ADDRESS<br><b>2407 Kenton Place, S.E.</b>  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>(None)</b> Last <b>Finnegan</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>26</b> Year <b>1960</b>  |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>November 10, 1915</b>   |   | 9. AGE (In years lost birthday) yrs. <b>44</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Aircraft Instrument Mechanic Aircraft</b>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Pennsylvania</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |
| 13. FATHER'S NAME<br><b>John Joseph Finnegan</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Catherine McAndrew</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b>   |                                  |   | 16. SOCIAL SECURITY NO.<br><b>WW II 170-10-8176</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>yes</b>  |                                  |   | INFORMANT Address<br><b>The Medical Record The Clinical Center, Bethesda 14, Maryland</b>  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma, right upper lobe bronchus</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>162.1</b> days<br><b>3 months</b>            |                                  |   |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                  |   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  |   | 20f. (City or town) (County) (State)   |   |   |
| 21. I certify that I attended the deceased from <b>January 25, 1960</b> to <b>January 26, 1960</b> , that I last saw the deceased alive on <b>January 26, 1960</b> , and that death occurred at <b>1:05 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>The Clinical Center January 26, 1960</b><br><b>National Institutes of Health Bethesda 14, Maryland</b> |                                  |   |  |   |   |
| ACTUAL SIGNATURE <b>Richard C. Mechanic</b>  |                                  |   | M.D. <b>The Clinical Center January 26, 1960</b>   |   |   |
| PHYSICIAN'S NAME (Type) <b>RICHARD C. MECHANIC, M. D.</b>  |                                  |   | National Institutes of Health Bethesda 14, Maryland  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>1-29-1960</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b> |   |
| 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Va.</b>   |                                  | 22e. REC'D BY REGISTRAR<br><b>JAN 27 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraw</b>             |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James T. Ryan, Inc.</b>   |                                  |   | ADDRESS<br><b>317 Pa. Ave., S.E.</b>   |   |   |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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- 15 -

James T. Ryan, Inc. 317 The Ave. S.E.

## 0808 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |  |   |  |   |
|---|----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |                                  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>                                      |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MARILEA NURSING HOME</b>   |                                  |  | d. STREET ADDRESS<br><b>8712 2nd Ave.</b>   |  |   |
| e. IS RESIDENCE ON A FARM<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |   |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ANCELLA</b> Middle <b>BOAG</b> Last <b>FISHER</b>   |                                  |  | 4. DATE OF DEATH<br>Month <b>Jan</b> Day <b>29</b> Year <b>1960</b>   |  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/14/71</b>  |  | 9. AGE (In years lost birthday)<br><b>88</b> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Calibrator</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Deep Sea Sounding Equipment Co.</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>WASHINGTON, D.C.</b> |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                  |  |   |  |   |
| 13. FATHER'S NAME<br><b>SAMUEL BALL FISHER</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>ANCELLA BOAG</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                                  |  | 16. SOCIAL SECURITY NO.<br><b>218-20-1869</b>   |  |   |
| 17. INFORMANT<br><b>Miss Phoebe D. Preston, 8608 2nd Ave.</b>   |                                  |  | Address   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>331X</b> <b>Hearted 2 vascular accident</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Long standing arteriosclerosis</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19<br>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work<br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>21. I certify that I attended the deceased from <b>Jan 28, 1960</b> to <b>Jan 29, 1960</b> that I last saw the deceased alive on <b>Jan 28, 1960</b> and that death occurred at <b>12:51 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <b>John S. Rogers</b> M.D. <b>1-29-60</b><br>PHYSICIAN'S NAME (Type) <b>JOHN S. ROGERS</b> |                                  |  |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>2/1/60</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ROCK CREEK CEMETERY</b>     |   |
| 22d. LOCATION (City, town, or county)<br><b>WASHINGTON, D.C.</b>  |                                  | (State)  |   |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PIMPHREY, INC.</b><br><b>Raymond A. Ziskas</b>   |                                  |  | ADDRESS<br><b>SILVER SPRING, MD.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 1 '60</b>  |
| 24b. REGISTRAR'S SIGNATURE<br><b>William S. K...</b>  |                                  |  |   |  |   |

TO HOSPITAL OR A DEDICATED PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE  
BUREAU OF PUBLIC HEALTH  
DIVISION OF VETERINARY MEDICINE  
OFFICE OF THE ASSISTANT SECRETARY FOR VETERINARY MEDICINE  
WASHINGTON, D. C. 20540

DATE: 10/10/68

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/68

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/68

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/68

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/68

TO: [illegible]

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SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/68

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/68



TO HOSPITAL OR A Dying Physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                              |   |  |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BETHESDA</b>   |                              | c. LENGTH OF STAY IN 1b<br><b>3 YEARS 57</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SUBURBAN HOSPITAL EMERGENCY ROOM</b>   |                              | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SAMUEL</b> Middle <b>CARR</b> Last <b>FLEMING</b>   |                              | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>13</b> Year <b>1960</b>   |  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>FEB. 22, 1870</b> |
| 9. AGE (In years last birthday)<br><b>89</b> yrs.   |                              | 10. IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>13</b> Hours <b>13</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALESMAN</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOSPITAL EQUIPMENT</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>ANDREW W. FLEMING</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>FRANCES TOLLER</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)   |                              | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b><br><b>PHYLLIS F. ACREE</b><br><b>DAUGHTER</b>   |  |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.<br>(b) <b>MYOCARDIAL INSUFFICIENCY</b><br>DUE TO<br>(c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>ONE HOUR</b><br><b>SIX YEARS</b><br><b>20 YEARS</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                              | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>JULY</b> , 1956, to <b>JAN 13, 1960</b> , that I last saw the deceased alive on <b>DEC. 29, 1960</b> , and that death occurred at <b>11:30 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>4630 Montgomery Ave, Bethesda, Md.</b> DATE SIGNED <b>1/13/60</b>                        |                              |   |  |
| ACTUAL SIGNATURE <b>Robert H. Coale</b>   |                              | M.D. <b>4630 Montgomery Ave, Bethesda, Md.</b>  |  |
| PHYSICIAN'S NAME (Type) <b>ROBERT N. COALE</b>  |                              |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 22b. DATE THEREOF<br><b>January 15, 1960</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ivy Hill Cemetery</b>  |                              | 22d. LOCATION (City, town, or county) (State)<br><b>Alexandria, Virginia.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Jeanne Funeral Home, Alexandria, Va.</b>   |                              | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 20 '60</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>  |                              |   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00853

0908

|   |   |   |   |        |      |       |      |   |  |
|---|---|---|---|--------|------|-------|------|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |   |        |      |       |      |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |   | c. LENGTH OF STAY IN lb<br><b>2 days-4 hr. 56</b>   |   |        |      |       |      |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Suburban Hospital</b>  |   | e. STREET ADDRESS<br><b>1 I45II Colesville Road</b>   |   |        |      |       |      |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>Jennie</b> Middle <b>N.E.</b> Last <b>Flood</b>  |   | <b>4. DATE OF DEATH</b> Month <b>Jan</b> Day <b>uary</b> Year <b>3</b> <b>19 60</b>   |   |        |      |       |      |   |  |
| <b>5. SEX</b><br><b>F emale</b>   | <b>6. COLOR OR RACE</b><br><b>White</b> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><b>II -10-74</b> |        |      |       |      |   |  |
| <b>9. AGE</b> (In years last birthday) <b>85</b> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>  |   | IF UNDER 1 YEAR   | IF UNDER 24 HRS.                            | Months | Days | Hours | Min. | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>H swf.</b> |  |
| IF UNDER 1 YEAR   | IF UNDER 24 HRS.                        |   |   |        |      |       |      |   |  |
| Months  | Days                                    |   |   |        |      |       |      |   |  |
| Hours   | Min.                                    |   |   |        |      |       |      |   |  |
| <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>----</b>   |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Sweden</b>   |   |        |      |       |      |   |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |   | <b>13. FATHER'S NAME</b><br><b>H ansson</b>   |   |        |      |       |      |   |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><b>Unknown</b>   |   | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)<br><b>no</b>  |   |        |      |       |      |   |  |
| <b>16. SOCIAL SECURITY NO.</b><br><b>none</b>   |   | <b>17. ADDRESS</b><br><b>Informant Lillian K. Taylor 9908 East B exhill Drive (daughter-in-law by former marriage) Kennington Md.</b>                           |   |        |      |       |      |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0</b> <b>Coronary insufficiency</b><br>DUE TO (b) <b>Arteriosclerotic heart disease with</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>arricular fibrillation and cardiac failure</b><br>DUE TO (c) <b>Generalized arteriosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)        |   |   |   |        |      |       |      |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |        |      |       |      |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a. m. 19<br>p. m.<br><b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State) |   |   |   |        |      |       |      |   |  |
| <b>21. I certify that I attended the deceased from</b> _____, 19____, to <b>January 3, 1960</b> , that I last saw the deceased alive on <b>January 2, 1960</b> , and that death occurred at <b>7:40 A.M.</b> , from the causes and on the date stated above.<br><b>ACTUAL SIGNATURE</b> <b>Aaron H. Traum</b> <b>M.D. 8237 Georgia Ave Silver Spring Md. Jan 3, 60</b><br><b>PHYSICIAN'S NAME (Type)</b> <b>Aaron H. Traum</b>  |   |   |   |        |      |       |      |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>   |   | <b>22b. DATE THEREOF</b><br><b>1-5-60</b>   |   |        |      |       |      |   |  |
| <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Ft. Lincoln Cemetery</b>  |   | <b>22d. LOCATION</b> (City, town, or county) (State)<br><b>Prince George Co., Md.</b>   |   |        |      |       |      |   |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Robert A. Humphrey</b>  |   | <b>24a. REC'D BY REGISTRAR</b><br><b>DATE JAN 5 '60</b>   |   |        |      |       |      |   |  |
| <b>24b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Kinn</b>  |   | <b>24c. ADDRESS</b><br><b>Bethesda, Md.</b>   |   |        |      |       |      |   |  |

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex and age

3. Date of death

4. Place of death

5. Cause of death

6. Manner of death

7. Signature of physician

8. Signature of registrar

9. Date

10. Signature of witness

## 0910 CERTIFICATE OF DEATH

00854

Reg. Dist. No.

|  |                                  |  |  |   |   |   |  |
|--|----------------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>District of Columbia</b> <b>COUNTY</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  |  |  | c. LENGTH OF STAY IN 1b<br><b>110 days</b>  |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |                                  |  |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b> <b>47x-3</b>                          |   |   |  |
| d. STREET ADDRESS<br><b>336 Bryant Street, NW</b>  |                                  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)  |                                  | First <b>Carrie</b> Middle <b>Theresa</b> Last <b>Foster</b>   |  | 4. DATE OF DEATH  |   | Month <b>January</b> Day <b>5</b> Year <b>1960</b>                    |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>August 17, 1907</b> |   | 9. AGE (In years last birthday)<br><b>52</b> yrs. | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>1</b> Hours <b>15</b> Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Nurses Aide</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Nursing</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                       |  |
| 13. FATHER'S NAME<br><b>Nelson Hughes</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Annie Young</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>577-12-8297</b>  |  | INFORMANT <b>The Medical Record</b> Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>abdominal wall, perforation ileum</b><br>DUE TO<br>(b) <b>Recurrent carcinoma of cervix, mesentery, pleura</b><br>DUE TO <b>Status post radical pelvic exenteration and</b><br>(c) <b>uretero-ileostomy</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>171X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>1 month</b><br><b>15 months</b> |                                  |  |  |   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>o. m.</b> <b>19</b><br>p. m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                  |  |
| 21. I certify that I attended the deceased from <b>September 17, 1952</b> , to <b>January 5, 1960</b> , that I last saw the deceased alive on <b>January 5, 1960</b> , and that death occurred at <b>9:15 P.</b> M., from the causes and on the date stated above.   |                                  |  |  |   |   |   |  |
| ACTUAL SIGNATURE <b>Seymour C. Nash M.D.</b>   |                                  |  |  | ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>1/6/60</b>  |   |   |  |
| PHYSICIAN'S NAME (Type) <b>Seymour C. Nash, M.D.</b>   |                                  |  |  | National Institutes of Health<br><b>Bethesda 14, Maryland</b>   |   |   |  |
| 22. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 22b. DATE THEREOF<br><b>1/9/60</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Memorial</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Suitland, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Brown + Davidson - 5635 - Eads - St. N.E.</b><br><b>John Brown - (549) -</b>  |                                  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 '60</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>                  |  |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained at the hospital or funeral home. The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of Commerce

Washington, D.C.

July 10, 1914

San Francisco

The National Bank of Commerce

San Francisco, California

Dear Sirs:

Reference is made to your letter of July 7, 1914.

Very truly yours,

W. A. Rorer

W. A. Rorer

San Francisco

Enclosed for you are two copies of the

Report of the

Committee on the

July 10, 1914

Very truly yours,

W. A. Rorer

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## CERTIFICATE OF DEATH

Reg. Dist. No. 215

00856

0912

|  |                                      |   |   |
|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>  |                                      | c. LENGTH OF STAY IN 1b<br><b>1hr 40min</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital</b>   |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Earle</b> Middle <b>Grace</b> Last <b>GARDNER</b>  |                                      | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>10</b> Year <b>1960</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Caucasian</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-18-85</b>                            |
| 9. AGE (In years lost birthday)<br><b>74</b> yrs.  |                                      | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  | 11. BIRTHPLACE (State or foreign country)<br><b>Louisiana</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                      | 13. FATHER'S NAME<br><b>Thomas Washington</b>   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Katherine Von Weber</b>   |                                      | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b>  |   |
| 16. SOCIAL SECURITY NO.<br><b>4714 No. Chelsea Lane</b>  |                                      | 17. INFORMANT<br><b>Theresa S. Gardner (W) Bethesda, Maryland</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteriosclerotic Cardiovascular disease</b><br>DUE TO<br>(c) _____ |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min.</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Pulmonary emphysema</b>  |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                      | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>                          |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>January 10, 1960</b> to <b>January 10, 1960</b> , that I last saw the deceased alive on <b>January 10, 1960</b> , and that death occurred at <b>1:40P</b> M, from the causes and on the date stated above.  |                                      |   |   |
| ACTUAL SIGNATURE <b>R.G. Galbraith Jr.</b>   |                                      | ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital</b>  |   |
| DATE SIGNED <b>1-10-60</b>   |                                      |   |   |
| PHYSICIAN'S NAME (Type) <b>R.G. GALBRAITH JR. LT MC USN</b>  |                                      | <b>Bethesda, Maryland</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                      | 22b. DATE THEREOF<br><b>1-14-60</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |                                      | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R. A. Pumphrey</b>  |                                      | 24a. REC'D BY REGISTRAR<br><b>Jan 13 '60</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                      |   |   |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. Naval Hospital, Bethesda, Md.

1-11-60

Washington National

Washington

Virginia

R.O. GILBERT JR. JR. MD USA

U.S. Naval Hospital

1-10-60

January 10

60

January 10

1:40P

January 10

60

U.S. Naval Hospital, Bethesda, Maryland

U.S. Naval Hospital, Bethesda, Maryland

Thomas Washington

Yes

Theresa E. Gardner (V) Bethesda, Maryland  
Richardine Von Weber  
4144 N. Orleans Lane

Washington

USA

Male Caucasian

8-10-52

74

Early

Grave

DARWIN

January

10

60

U.S. Naval Hospital

4144 N. Orleans Lane

Bethesda (Mental)

1st. Admin

Bethesda (Mental)

Washington

MARYLAND

WASHINGTON



CERTIFICATE OF DEATH

0235

DATE OF DEATH

PLACE OF DEATH

TO WHOM ISSUED

BY WHOM ISSUED

REMARKS

SIGNATURE OF DECEASED

SIGNATURE OF WITNESS

SIGNATURE OF PHYSICIAN

SIGNATURE OF CLERK

SIGNATURE OF JUDGE

SIGNATURE OF SHERIFF

SIGNATURE OF CONSTABLE

SIGNATURE OF TOWNSHIP CLERK

SIGNATURE OF COUNTY CLERK

SIGNATURE OF STATE CLERK

SIGNATURE OF U.S. MARSHAL

SIGNATURE OF U.S. ATTORNEY

SIGNATURE OF U.S. DISTRICT JUDGE

SIGNATURE OF U.S. SENATOR

SIGNATURE OF U.S. REPRESENTATIVE





U.S. DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D.C.

1-27-50 St. Anthony's Marine Corps Hospital  
Baltimore, Maryland

H. E. CANADA, JR., CAPT, MC, USA  
Baltimore 14, Maryland

U. S. Naval Hospital  
1-24-50

January 23 1950  
June 22 1950  
January 24 1950

Colonel, Adjutant General  
1. 1.

Mr. E.W. Hogan (S), name on file

J. Leslie GUMMING  
Mary Walsh

XXXX Language School - - - - -  
Pennsylvania

1-21-50  
1-21-50

1-21-50  
1-21-50

U.S. National Naval Medical Center  
Center

Bethesda (Main)  
Bethesda (Main)

Montgomery  
Maryland  
Montgomery

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00859

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>11 days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Suburban Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Susan</b> Middle <b>B.</b> Last <b>Godbold</b>  |                                  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>28</b> Year <b>1960</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 21, 1876</b> |
| 9. AGE (In years last birthday)<br><b>83 yrs.</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Mass.</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Walter Simmons</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Hume</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no, or unknown)<br><b>None</b>  |                                  | 16. SOCIAL SECURITY NO. (If you have war or dates of service)<br><b>None</b>   |   |
| 17. INFORMANT<br><b>Daughter</b>  |                                  | Address<br><b>Josephine G. Havens</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage, posterior, focal</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Coronary insufficiency</b><br>(c) <b>Arteriosclerotic coronary artery disease</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>acute</b><br><b>years</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Dissection of aorta with peritonitis, status postoperative</b>  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>1/17/60</b> to <b>1/28/60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/27/60</b> , 19 <b>60</b> , and that death occurred at <b>5:00</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>4630 Montgomery Ave. Bethesda, Md.</b> DATE SIGNED <b>1/28/60</b>                   |                                  |  |   |
| ACTUAL SIGNATURE<br><b>Emmett M. Madigan</b> M.D.   |                                  | PHYSICIAN'S NAME (Type)<br><b>Emmett Madigan 4630 Montgomery Ave. Bethesda, Maryland</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |                                  | 22b. DATE THEREOF<br><b>1-28-60</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Prince George Co., Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>ROBERT A. PUMPHREY</b> ADDRESS<br><b>Bethesda, Maryland</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 29 '60</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. House</b>  |                                  |  |   |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

— 52 —

1502

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00860

0915

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Barnesville</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>83 yrs</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Gertrude</b> Middle <b>Worthington</b> Last <b>Gough</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>12</b> Year <b>19 60</b>  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Oct. 5-1876</b>                       |  |
| 9. AGE (In years last birthday)<br><b>83</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. |  | 11. IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Robert V. Wood</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Ann Virginia Worthington</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |  |  |
| 17. INFORMANT<br><b>Mrs Virginia Giddings, Barnesville, Md</b>  |  |  |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b><br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Pulmonary Edema</b><br>DUE TO<br>(c) <b>Arterio Sclerotic Heart disease</b> |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paralysis Agitans</b>  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <b>10 Nov., 1957</b> to <b>12 Jan., 1960</b> , that I last saw the deceased alive on <b>16 Jan., 1960</b> , and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Gordon M. Smith</b>   |  |  |  | ADDRESS (Street, city or town, state) <b>Barnesville, Md</b> DATE SIGNED <b>12 Jan '60</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  | 22b. DATE THEREOF<br><b>1/14/60</b>  |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Monocacy</b>   |  |  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Beallsville, Md</b>  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Constance C. Hilton</b>  |  |  |  | 24a. REC'D BY REGISTRAR<br><b>DATE JAN 15 '60</b>  |  |  |  |
| ADDRESS<br><b>Barnesville, Md.</b>  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>   |  |  |  |

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1917

1070

NAME OF DECEASED \_\_\_\_\_

AGE \_\_\_\_\_

SEX \_\_\_\_\_

RACE \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_

PLACE OF DEATH \_\_\_\_\_

Cause of Death \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Signature of Registrar \_\_\_\_\_



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0827

## CERTIFICATE OF DEATH

00861

Reg. Dist. No.

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>PRINCE GEORGES</b>        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b> <b>16-53-2</b>                                    |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Oak Haven Convalescent Home</b>  |   | d. STREET ADDRESS<br><b>6916 Prince Georges Ave.</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>XENIA</b> Middle <b>OREST</b> Last <b>GOUTAN</b>  |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>5</b> Year <b>1960</b>   |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/24/1879</b>                                     |
| 9. AGE (In years last birthday)<br><b>80</b>  |   | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 24 HRS.<br>Hours _____ Min. _____                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Music Teacher</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>RUSSIA</b>               |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>Russia</b>   |   | 13. FATHER'S NAME<br><b>Orest Kmita</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)<br><b>no</b>                                    |  |
| 16. SOCIAL SECURITY NO.<br><b>578-48-0166</b>   |   | 17. INFORMANT<br><b>Adam J. Gootan</b> Address <b>6916 Prince Georges Ave Takoma Park, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Attacked (Coronary thrombosis)</b><br>DUE TO <b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Malnutrition Fractured Left Femur</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 minutes</b><br><b>Several years</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                     |
| 21. I certify that I attended the deceased from <b>November, 1959</b> , to <b>January 5, 1960</b> , that I last saw the deceased alive on <b>January 3, 1960</b> , and that death occurred at <b>3:20 P.M.</b> from the causes and on the date stated above.  |   |  |  |
| ACTUAL SIGNATURE<br><b>Stuart L. Nelson</b>   |   | ADDRESS (Street, city or town, state)<br><b>7600 Carroll Avenue Takoma Park, Md.</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>Stuart L. Nelson</b>  |   | DATE SIGNED<br><b>Washington Sanitarium and Hospital</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>1/9/60</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D.C.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Co.</b>   |   | 24a. REC'D BY REGISTRAR<br><b>JAN 7 '60</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Carroll L. Hines</b>                    |

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNCLASIFIED CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH

## 0916 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |   | c. LENGTH OF STAY IN lb<br><b>34 days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Suburban Hospital</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) <b>Catherine A Graber</b>  |   | 4. DATE OF DEATH <b>January 22 19 60</b>   |   |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>W</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>9/19/1874</b>   |
| 9. AGE (In years last birthday) <b>85</b>  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  | 11. IF UNDER 24 HRS.<br>Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Wil helm Preuss</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO. <b>none</b>  |   |
| 17. INFORMANT <b>Mrs. Lois M.L. Shanks (granddaughter)</b>   |   | Address <b>same</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal anemia</b><br><b>446x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Nephrosclerosis advanced</b> DUE TO<br>(c) <b>Arteriosclerosis, general, advanced.</b> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b><br><b>2 yrs +</b><br><b>" " "</b>              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rt. hemiplegia with aphasia</b>   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>1955</b> to <b>Jan 22, 1960</b> that I last saw the deceased alive on <b>Jan 21, 1960</b> and that death occurred at <b>9:50 A.M.</b> from the causes and on the date stated above.   |   |  |   |
| ACTUAL SIGNATURE <b>Stewart Clapp</b>  |   | ADDRESS (Street, city or town, state) <b>3921 Ingomar St NW Wash DC</b>  |   |
| PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>   |   | DATE SIGNED <b>1/22/60</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF   | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State)   |
| <b>Cremation</b>   | <b>1/22/60</b>  | <b>Fort Lincoln</b>  | <b>Colmar Manor Md.</b>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Chry Chase Funeral Home</b>  |   | ADDRESS <b>3 Wisconsin Wash DC</b>   |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 25 '60</b>  |   | 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thayer</b>   |   |

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

1000

DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

|                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |
|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name of deceased       |  | Age                    |  | Sex                    |  | Race                   |  | Marital status         |  | Occupation             |  | Cause of death         |  | Date of death          |  | Place of death         |  | Signature of physician |  | Signature of registrar |  |
| John Doe               |  | 45                     |  | Male                   |  | White                  |  | Married                |  | Teacher                |  | Heart disease          |  | Jan 15, 1950           |  | Home                   |  | J. Smith               |  | A. Jones               |  |
| Place of birth         |  | Date of birth          |  | Date of death          |  | Time of death          |  | Time of day            |  | Time of year           |  | Time of day            |  | Time of year           |  | Time of day            |  | Time of year           |  | Time of day            |  |
| New York               |  | Jan 1, 1905            |  | Jan 15, 1950           |  | 10:00 AM               |  | 10:00 AM               |  | 10:00 AM               |  | 10:00 AM               |  | 10:00 AM               |  | 10:00 AM               |  | 10:00 AM               |  | 10:00 AM               |  |
| Place of death         |  | Date of death          |  | Time of death          |  | Time of day            |  | Time of year           |  | Time of day            |  | Time of year           |  | Time of day            |  | Time of year           |  | Time of day            |  | Time of year           |  |
| Home                   |  | Jan 15, 1950           |  | 10:00 AM               |  | 10:00 AM               |  | 10:00 AM               |  | 10:00 AM               |  | 10:00 AM               |  | 10:00 AM               |  | 10:00 AM               |  | 10:00 AM               |  | 10:00 AM               |  |
| Signature of physician |  | Signature of registrar |  | Signature of physician |  | Signature of registrar |  | Signature of physician |  | Signature of registrar |  | Signature of physician |  | Signature of registrar |  | Signature of physician |  | Signature of registrar |  | Signature of physician |  |
| J. Smith               |  | A. Jones               |  | J. Smith               |  | A. Jones               |  | J. Smith               |  | A. Jones               |  | J. Smith               |  | A. Jones               |  | J. Smith               |  | A. Jones               |  | J. Smith               |  |

0862

## CERTIFICATE OF DEATH

Reg. Dist. No. 00863

|  |                               |  |                                      |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>            |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pensington</i>   |                               | c. LENGTH OF STAY IN 1b <i>2 mo 17 days</i>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Carroll Hall Sanatorium</i>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Ida</i> Middle Last <i>Gray</i>  |                               | 4. DATE OF DEATH<br>Month <i>January</i> Day <i>20</i> Year <i>1960</i>  |                                      |
| 5. SEX <i>female</i>   | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept-20-1872</i> |
| 9. AGE (In years last birthday) <i>87</i> yrs.   |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <i>4</i> Days <i>1</i> Hours <i>1</i> Min. <i>2</i>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <i>housewife</i>   |                                      |
| 11. BIRTHPLACE (State or foreign country) <i>Montgomery Co., Md.</i>   |                               | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |                                      |
| 13. FATHER'S NAME <i>Amos Corley</i>   |                               | 14. MOTHER'S MAIDEN NAME <i>Grimes</i>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <i>none</i>  |                                      |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>acute cardiac failure</i><br>260x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>diabetes</i><br>DUE TO (c) <i>high arterial tension</i> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 1/2 hours</i><br><i>years</i><br><i>years</i>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)  |                               |  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>                          |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <i>Nov-3-</i> 19 <i>59</i> , to <i>Jan-20-</i> 19 <i>60</i> , that I last saw the deceased alive on <i>Jan-4-</i> 19 <i>60</i> , and that death occurred at <i>9 P.</i> M. from the causes and on the date stated above.   |                               |  |                                      |
| ACTUAL SIGNATURE <i>William C. Miller</i> M.D.   |                               | ADDRESS (Street, city or town, state) <i>7-Brook Ave., Gaithersburg, Md.</i>   |                                      |
| PHYSICIAN'S NAME (Type) <i>William C. MILLER</i>   |                               | DATE SIGNED <i>Jan 22 '60</i>  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |                               | 22b. DATE THEREOF <i>1/23/60</i>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Monocacy</i>   |                               | 22d. LOCATION (City, town, or county) (State) <i>Beallsville, Md.</i>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler</i> ADDRESS <i>1331 E. Montg. Ave. Rockville, Md.</i>  |                               | 24a. REC'D BY REGISTRAR <i>Jan 22 '60</i>  |                                      |
| 24b. REGISTRAR'S SIGNATURE <i>Cuthbert S. Hume</i>   |                               |  |                                      |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No. 00864

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN Hosp.</b>   |   | d. STREET ADDRESS <b>19804 HOLMHURST ST</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JEROME</b> Middle <b>B.</b> Last <b>GREEN</b>  |   | 4. DATE OF DEATH<br>Month <b>JAN</b> Day <b>27</b> Year <b>1960</b>   |   |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>W</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>DEC 28, 1898</b>                        |
| 9. AGE (In years lost birthday) <b>61</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.<br>Months Days Hours Min.              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PSYCHIST</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>JOHNS HOPKINS</b>  | 11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>   |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>   |   | 13. FATHER'S NAME <b>Emanuel B. Green</b>   |   |
| 14. MOTHER'S MAIDEN NAME <b>PAULINE BOLEY</b>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |   |
| 16. SOCIAL SECURITY NO. <b>Yes</b>   |   | INFORMANT Address <b>MRS. BEATRIX MOOD GREEN</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1 CORONARY THROMBOSIS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>24 HOURS</b><br>(c) |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                        |
| 21. I certify that I attended the deceased from <b>JAN 1</b> , 19 <b>57</b> , to <b>JAN 27</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>JAN 27</b> , 19 <b>60</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.                          |   |   |   |
| ACTUAL SIGNATURE <b>Samuel J. N. Sugar</b> M.D.  |   | ADDRESS (Street, city or town, state) <b>4300 KAYWOOD DRIVE</b>   |   |
| PHYSICIAN'S NAME (Type) <b>SAMUEL J. N. SUGAR</b>  |   | DATE SIGNED <b>JAN 27 '60</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |   | 22b. DATE THEREOF <b>1-30-60</b>  | 22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b> |
| 22d. LOCATION (City, town, or county) <b>Rockville, Maryland</b>   |   | (State)   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>   |   | 24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>  |   |
| ADDRESS <b>Bethesda, Maryland</b>  |   | DATE <b>JAN 29 '60</b>  |   |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2. The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2. The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2. The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2. The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]

PLACE OF BURIAL: [illegible]

NAME OF MINISTER: [illegible]

NAME OF FUNERAL HOME: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF CHURCH: [illegible]

NAME OF PASTOR: [illegible]

NAME OF DEACON: [illegible]

NAME OF SINGER: [illegible]

NAME OF ORGANIST: [illegible]

NAME OF READER: [illegible]

NAME OF PRAYER LEADER: [illegible]

NAME OF BIBLE READER: [illegible]

NAME OF SINGER: [illegible]

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
00865  
BOL  
CERTIFICATE OF DEATH

|  |  |                                  |  |  |  |   |  |
|--|--|----------------------------------|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laytonsville</u>   |  |                                  |  | c. LENGTH OF STAY IN 1b <u>Life</u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  |                                  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Jeffrey</u> <u>Magruder</u> <u>Griffith, Jr.</u>  |  |                                  |  | 4. DATE OF DEATH <u>Jan.</u> <u>24</u> <u>19 60</u>  |  |   |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>    |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>July 13, 1913</u>                                     |  |
| 9. AGE (In years last birthday) <u>46</u> yrs.   |  | IF UNDER 1 YEAR Months Days      |  | IF UNDER 24 HRS. Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>  |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>USA</u>                      |  |
| 13. FATHER'S NAME <u>Jeffrey M. Griffith, Sr.</u>  |  |                                  |  | 14. MOTHER'S MAIDEN NAME <u>Lillian Neel</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |  |                                  |  | 16. SOCIAL SECURITY NO. <u>217-36-8093</u>   |  |   |  |
| 17. INFORMANT <u>Mrs. Jeffrey M. Griffith, Sr.</u> Address <u>Rt. #1 Gaithersburg, Md.</u>   |  |                                  |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>241X</u> <u>Branchopneumonia, streptococcus</u><br>DUE TO (b) <u>Bronchial asthma</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>15 years</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9 days</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u> |  |                                  |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>  |  |                                  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    |  |
| 20f. (City or town) (County) (State)   |  |                                  |  |  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 13, 1960</u> to <u>Jan. 24, 1960</u> that (I) (we) last saw the deceased alive on <u>January 24, 1960</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.   |  |                                  |  |  |  |   |  |
| 22a. SIGNATURE <u>James P. Kerr</u>  |  |                                  |  | 22b. DATE SIGNED   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. James P. Kerr</u>  |  |                                  |  | 22d. ADDRESS <u>Damascus, Maryland</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>1-27-60</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Neelsville</u>   |  | 23d. LOCATION (City, town, or county) (State) <u>Neelsville, Maryland</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Frankie H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>   |  |                                  |  | 25a. REC'D BY REGISTRAR DATE <u>JAN 27 '60</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>                         |  |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0919 CERTIFICATE OF DEATH

00866

Reg. Dist. No.

|   |                               |  |                                     |
|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Penna</u> b. COUNTY <u>LUZERNE</u>                  |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilkes - BARRE</u>   |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4511 Arondale St.</u>   |                               | d. STREET ADDRESS <u>94 OAK ST 75X-3</u>   |                                     |
| 3. NAME OF DECEASED (Type or print) First <u>Kathryn</u> Middle <u>HANFORD</u> Last <u>HANFORD</u>  |                               | 4. DATE OF DEATH Month <u>JAN</u> Day <u>28</u> Year <u>1960</u>   |                                     |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 9 1889</u> |
| 9. AGE (In years lost birthday) <u>71</u> yrs.  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                     |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u>  |                                     |
| 13. FATHER'S NAME <u>BENJAMIN F. WILLIAMS</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>CLARA LUCKS</u>  |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)   |                                     |
| 17. INFORMANT <u>CLARA W. Partington</u>  |                               | Address <u>Bethesda, Md</u>  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>151X METASTATIC GASTRIC CARCINOMA</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                               | INTERVAL BETWEEN ONSET AND DEATH <u>2 MO, 9695</u>   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                               |  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. _____ 19 _____   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____  |                               | 20f. (City or town) _____ (County) _____ (State) _____   |                                     |
| 21. I certify that I attended the deceased from <u>JAN 28, 1960</u> , to <u>JAN 27, 1960</u> , that I last saw the deceased alive on <u>JAN 27, 1960</u> , and that death occurred at <u>1 P. M.</u> , from the causes and on the date stated above.  |                               |  |                                     |
| ACTUAL SIGNATURE <u>A. J. Brennan</u> M.D.  |                               | ADDRESS (Street, city or town, state) <u>Bethesda, Md</u> DATE SIGNED <u>1/28/60</u>   |                                     |
| PHYSICIAN'S NAME (Type) <u>A. J. BRENNAN</u>  |                               | Bethesda, Maryland   |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>2/1/60</u>  |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill Cemetery</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>Wilkes-Barre, Penna.</u>  |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>  |                               | 24a. REC'D BY REGISTRAR <u>DATE JAN 29 '60</u>   |                                     |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>   |                               |  |                                     |





0809

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b><br>c. LENGTH OF STAY IN 1b<br><b>19 years</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>500 SHERBROOK DRIVE</b> |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>56 SILVER SPRING</b><br>d. STREET ADDRESS<br><b>500 SHERBROOK DRIVE</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>NANCY</b><br>Middle<br><b>M.</b><br>Last<br><b>HANNA</b>   |                                  | 4. DATE OF DEATH<br>Month<br><b>JANUARY</b><br>Day<br><b>16</b><br>Year<br><b>19 60</b>   |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>3/30/74</b>                                      |
| 9. AGE (In years last birthday)<br><b>85</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months<br><b>16</b>  | 11. IF UNDER 24 HRS.<br>Days<br><b>19</b><br>Hours<br><b>60</b><br>Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Missouri</b>            |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                  | 13. FATHER'S NAME<br><b>WALLACE MITCHELL</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>MARTHA LEWIS</b>   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |   |
| 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |                                  | 17. INFORMANT<br>Address<br><b>Mrs. Gladys L. MacInnis, 500 Sherbrook Dr.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>331x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c)                       |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>16 mos</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  | 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |   |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   |
| 20f. (City or town)<br><b>Silver Spring, Md.</b>  |                                  | (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>9/10/58</b> , 19 <b>58</b> , to <b>1/16</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/15</b> , 19 <b>60</b> , and that death occurred at <b>6:15</b> M., from the causes and on the date stated above.   |                                  |   |   |
| ADDRESS (Street, city or town, state)<br><b>2716 Kirkwood Place</b>   |                                  | DATE SIGNED<br><b>1/16/60</b>   |   |
| ACTUAL SIGNATURE<br><b>Earl W. Graeff</b>   |                                  | M.D. <b>W. H. Gattavill, Md.</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>EARL W. GRAEFF, M.D.</b>  |                                  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>1/19/60</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>COLESVILLE CEMETERY</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>MONTGOMERY COUNTY, MD.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PUMPHREY, INC.</b><br><b>Raymond E. Ziska</b>  |                                  | ADDRESS<br><b>SILVER SPRING, MD.</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>JAN 19 '60</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |   |



## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                               |  |                                   |   |   |
|---|-------------------------------|--|-----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>0920</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barnesville</b><br>c. LENGTH OF STAY IN 1b <b>92 yrs</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barnesville</b><br>d. STREET ADDRESS |                                   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>White</b> Last <b>Hays</b>   |                               | 4. DATE OF DEATH<br>Month <b>Jan</b> Day <b>15</b> Year <b>19 60</b>   |                                   |   |   |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>10-2-1867</b> | 9. AGE (In years last birthday) <b>92</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>  |                                   | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>   |                               | 13. FATHER'S NAME <b>Richard T. White</b>  |                                   | 14. MOTHER'S MAIDEN NAME <b>Mary Waters</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. <b>None</b>  |                                   | INFORMANT Address <b>Shirley Hays, Barnesville, Md</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anemia due to chronic blood loss</b><br>578x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hemorrhage, Gastro-intestinal, undet.</b><br>DUE TO<br>(c) |                               | INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>  |                                   | 3 weeks   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arterosclerosis; Cerebro-vascular accident (stabilized)</b>  |                               |  |                                   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |   |
| 20f. (City or town)   |                               | (County)   |                                   | (State)   |   |
| 21. I certify that I attended the deceased from <b>25 Dec, 1959</b> to <b>15 Jan, 1960</b> , that I last saw the deceased alive on <b>15 Jan 1960</b> , and that death occurred at <b>11:40 P.M.</b> from the causes and on the date stated above.  |                               |  |                                   |   |   |
| ACTUAL SIGNATURE <b>Goedon M. Smith</b>   |                               | ADDRESS (Street, city or town, state) <b>Barnesville, Md</b>   |                                   | DATE SIGNED <b>17 Jan 60</b>  |   |
| PHYSICIAN'S NAME (Type)   |                               |  |                                   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>1/18/60</b>   |                                   | 22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>  |   |
| 22d. LOCATION (City, town, or county) <b>Beallsville, Maryland</b>  |                               | (State)  |                                   |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hillon</b>   |                               | ADDRESS <b>Barnesville, Md</b>   |                                   | 24a. REC'D BY REGISTRAR <b>Jan 19 60</b>  |   |
| 24b. REGISTRAR'S SIGNATURE <b>Charles L. Haines</b>   |                               |  |                                   |   |   |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF DEATH

0332

Deceased's Name: James H. Jones  
Date of Death: 1-1-1907  
Place of Death: Home  
Cause of Death: Heart Disease  
Age: 65  
Sex: Male  
Occupation: Farmer  
Residence: 123 Main St., Jonesville, Va.  
Signature of Physician: Dr. J. H. Smith  
Signature of Undertaker: Wm. H. Jones

*[Faint, illegible text, possibly a signature or additional notes]*

## CERTIFICATE OF DEATH

Reg. Dist. No.

00869

0921

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Pennsylvania</b> b. COUNTY                             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>30 days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Veronica</b> Middle <b>Marie</b> Last <b>Horack</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>12</b> Year <b>1960</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>              |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>October 12, 1924</b>                                |  |
| 9. AGE (In years lost birthday)<br><b>35</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  | 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>William Huber</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Agnes (Unknown)</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>Unascertainable</b>   |  |  |  |
| INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure</b><br>754.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.<br>(b) <b>Empyema</b> DUE TO<br>(c) <b>Tetralogy of Fallot</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>3 weeks</b><br><b>Life</b>  |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)     |  |
| 20f. (City or town) (County) (State)   |  |   |  | 20g. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <b>December 13, 1959</b> , to <b>January 12, 1960</b> , that I last saw the deceased alive on <b>January 12, 1960</b> , and that death occurred at <b>7:05 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>1-13-60</b><br>ACTUAL SIGNATURE <b>Charles A. Chidsey</b> M.D. <b>National Institutes of Health</b><br>PHYSICIAN'S NAME (Type) <b>Charles A. Chidsey, M.D.</b> <b>Bethesda 14, Maryland</b> |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>1-16-60</b>           |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Josephs Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Jim Thorpe, Penna.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphyrey, Bethesda, Maryland</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>JAN 15 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Fraws</b>                       |  |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the hospital prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert A. Humphrey, Bethesda, Maryland

1-15-55 Dr. Joseph Gennery Jim Thorpe, Pennsylvania

Charles A. Gennery, M.D., Bethesda, Maryland

The Clinical Center  
National Institutes of Health  
Bethesda, Maryland

January 12

December 17 1955  
7:00 PM

Technology of Relief

Report

Charles Gennery

Unascertainable The Clinical Center, Bethesda, Maryland

William Huber

Honorable

Honorable

Pennsylvania

Female White

October 12, 1951

Veronica

Marie

Horack

January

The Clinical Center, Bethesda, Md., Inc., 313 South Bacon Street

Bethesda

30 days

Hannett Square

Pennsylvania



Item 8 Film G255 2-3-60 et  
0810 CERTIFICATE OF DEATH

00870

Reg. Dist. No.

|  |                                   |  |   |
|--|-----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>DC</b> b. COUNTY <b>✓</b>                           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>  |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 47x-3</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ledeau Gardens Nursing Home</b>  |                                   | d. STREET ADDRESS <b>1835 K St NW</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |   |
| 3. NAME OF DECEASED (Type or print) <b>Clara E Howe</b>  |                                   | 4. DATE OF DEATH <b>January 22 1960</b>  |   |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>Caucasian</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>1874 Oct 21, 1874</b>     |
| 9. AGE (In years last birthday) <b>85</b>  |                                   | 10. IF UNDER 1 YEAR <b>Months Days Hours Min.</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Atty's office</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>Grove City Pa</b>   |                                   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |
| 13. FATHER'S NAME <b>William H. Howe</b>   |                                   | 14. MOTHER'S MAIDEN NAME <b>Jane Miller</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                                   | 16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Paul Sedgewick 910 17th St NW</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b><br>203X DUE TO <b>Acute Bronchopneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Multiple Myeloma ?</b><br>(c) <b>Multiple Myeloma ?</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b> |                                   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>December 59</b> to <b>Jan 22 60</b> , that I last saw the deceased alive on <b>Jan 22 60</b> , and that death occurred at <b>11:10 a</b> M, from the causes and on the date stated above.   |                                   |  |   |
| ACTUAL SIGNATURE <b>Robert T. Thibadeau</b>  |                                   | ADDRESS (Street, city or town, state) <b>10609 Concord Street Jan 22, 1960</b> DATE SIGNED   |   |
| PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>   |                                   | <b>Kensington, Maryland</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF                 | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State) |
| <b>Burial</b>  | <b>1-25-60</b>                    | <b>Cedar Hill</b>  | <b>Suitland Md</b>                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b>  |                                   | ADDRESS <b>4812 Georgia Ave NW</b>   |   |
| 24a. REC'D BY REGISTRAR  |                                   | 24b. REGISTRAR'S SIGNATURE   |   |
| DATE <b>JAN 27 60</b>  |                                   | <b>Arthur L. Kraus</b>   |   |

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

1910 CERTIFICATE OF DEATH

1. Name of deceased: *William H. [illegible]*  
2. Age: *45*  
3. Sex: *Male*  
4. Date of death: *Oct 21, 1910*  
5. Place of death: *Home*  
6. Cause of death: *Heart disease*  
7. Signature of physician: *[illegible]*  
8. Signature of registrar: *[illegible]*  
9. Date of registration: *Oct 22, 1910*  
10. Place of registration: *[illegible]*

## CERTIFICATE OF DEATH

Reg. Dist. No.

00871

0922

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>6 days</b>   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |                                  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Joseph</b> Middle <b>Francis</b> Last <b>Huber</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>21</b> Year <b>19 60</b>   |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 20, 1905</b>   |  | 9. AGE (In years lost birthday)<br><b>54 yrs.</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Custodial officer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Penal Institution</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>     |
| 13. FATHER'S NAME<br><b>Oscar Huber</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Hines</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO. <b>919-36-2056</b><br>INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>                 |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septicemia with Shock</b><br>203x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple Myeloma</b><br>DUE TO (c) <b>Amyloid Heart Disease</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>9 Months</b> |                                  |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |   |
| 21. I certify that I attended the deceased from <b>January 15, 19 60</b> to <b>January 21, 19 60</b> , that I last saw the deceased alive on <b>January 21, 19 60</b> , and that death occurred at <b>11:10 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |                                  |   |  |  |   |
| ACTUAL SIGNATURE <b>Lawrence A. Gaydos</b>   |                                  | M.D. <b>The Clinical Center</b> <b>1-21-60</b>  |  |  |   |
| PHYSICIAN'S NAME (Type) <b>LAWRENCE A. GAYDOS, M.D.</b>  |                                  | <b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>1-25-60</b>  |                                  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Morland Park</b>  |   |
|  |                                  |   |  | 22d. LOCATION (City, town, or county) (State)<br><b>BALTO MD</b>   |   |
| 23a. FUNERAL DIRECTOR'S SIGNATURE<br><b>Leonard J. Buck</b>  |                                  | ADDRESS<br><b>5305 Harford A</b>  |  | 24a. REC'D BY REGISTRAR<br><b>JAN 26 '60</b>   |   |
|  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>   |   |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1953

Informant

Relationship

Signature

Residence

Age

Sex

1000 11th Avenue

The Clinical Center, Bethesda, Md.

1-21-53

Secretary

Huber

Francis

Joseph

21

August 20, 1903

White

Male

U.S.A.

Residence

Local Institution

Physician

Physician

Physician

The National Heart

Department with Brock

Initials of Physician

Physician's Name

9 Months

January 12, 1953

11:00

January 12

1-21-53

The Clinical Center

National Institutes of Health

Bethesda, Md., Maryland

JAMES A. HAYES, M.D.

## 0923 CERTIFICATE OF DEATH

Reg. Dist. No. 215

|   |  |                                      |  |   |  |  |  |
|---|--|--------------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |  |                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. COUNTY <b>Maryland</b> <b>Charles</b>                           |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |  |                                      |  | c. LENGTH OF STAY IN 1b<br><b>20hr 27min</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>   |  |                                      |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HUJIK</b> Middle Last   |  |                                      |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>13</b> Year <b>1960</b>   |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Caucasian</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>January 12, 1960</b>                            |  |
| 9. AGE (In years lost birthday)<br>yrs.   |  | IF UNDER 1 YEAR<br>Months            |  | IF UNDER 24 HRS.<br>Days  |  | Hours <b>20</b> Min <b>27</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |  |                                      |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- - - - -</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Bethesda, Maryland</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |                                      |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Roger "C" HUJIK</b>   |  |                                      |  | 14. MOTHER'S MAIDEN NAME<br><b>Dorothy F. DANEK</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |                                      |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |  |  |
| INFORMANT<br><b>Hospital Records</b>  |  |                                      |  | Address   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Perinatal Asphyxia</b><br><b>762.5</b> DUE TO <b>Prematurity</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.<br>(b) DUE TO<br>(c)                          |  |                                      |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                                      |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                      |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                      |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |  |                                      |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>                          |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |                                      |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <b>January 12, 1960</b> , to <b>January 13, 1960</b> , that I last saw the deceased alive on <b>January 13, 1960</b> , and that death occurred at <b>6:26P</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>U. S. Naval Hospital 1-14-60</b> |  |                                      |  |   |  |  |  |
| ACTUAL SIGNATURE <b>F. W. GRELLO</b>  |  |                                      |  | PHYSICIAN'S NAME (Type) <b>F. W. GRELLO, LT, MC, USN</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                                      |  | 22b. DATE THEREOF<br><b>1-18-60</b>   |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |  |                                      |  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b>  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R. A. Pumphrey</b>   |  |                                      |  | 24a. REC'D BY REGISTRAR<br><b>JAN 18 '60</b>  |  |  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. K...</b>   |  |                                      |  |   |  |  |  |

2051251XV0

# CERTIFICATE OF BIRTH

0013

Maryland

Montgomery

Indian Head

20th St. Wm

Richards (Rural)

App. 183-River View Village

U. S. Naval Hospital

HULLIN

January 13

1

January 18, 1900

Canadian

Male

Richards, Maryland

None

Dorothy T. Dyer

Robert C. HULLIN

Hospital Records

None

No

January 18

January 18

0:50P

January 18

U. S. Naval Hospital

Richards 14, Maryland

T. F. CHAND, 14, NO, MD

Arlington

Arlington Hospital

1-10-00

Birth

U. S. Naval Hospital, Richards, Md.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G255 1-29-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No. **00873**

|  |                  |   |  |  |  |   |  |   |  |                 |                  |        |      |       |      |
|--|------------------|---|--|--|--|---|--|---|--|-----------------|------------------|--------|------|-------|------|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Rockville</u><br>c. LENGTH OF STAY IN lb <u>30 days</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverly Sanitarium, Rockville Pk.</u>  |                  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Connecticut</u> b. COUNTY <u>District of Columbia</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norwich</u><br>d. STREET ADDRESS <u>39 Harland Road</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |                 |                  |        |      |       |      |
| <b>3. NAME OF DECEASED</b> (Type or print) First Middle Last<br><u>Mrs Julia Weld Huntington</u>   |                  |   |  | <b>4. DATE OF DEATH</b> Month Day Year<br><u>JAN 20 1960</u>   |  |   |  |   |  |                 |                  |        |      |       |      |
| <b>5. SEX</b><br><u>Female</u>   |                  | <b>6. COLOR OR RACE</b><br><u>White</u> |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><u>March 11, 1878</u>                              |  | <b>9. AGE</b> (In years last birthday) <u>81</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table> |  | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Months | Days | Hours | Min. |
| IF UNDER 1 YEAR  | IF UNDER 24 HRS. |   |  |  |  |   |  |   |  |                 |                  |        |      |       |      |
| Months   | Days             |   |  |  |  |   |  |   |  |                 |                  |        |      |       |      |
| Hours  | Min.             |   |  |  |  |   |  |   |  |                 |                  |        |      |       |      |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>- - - - -</u>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Roxbury, Mass.</u>     |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |  |                 |                  |        |      |       |      |
| <b>13. FATHER'S NAME</b><br><u>Franklin B. Weld</u>  |                  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Loretta Barton</u>   |  |   |  |   |  |                 |                  |        |      |       |      |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |                  |   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>none</u>  |  | <b>INFORMANT</b> Address<br><u>Mr. Louis Allwine</u>                          |  |   |  |                 |                  |        |      |       |      |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary edema. Cerebral hemorrhage.</u><br>331X DUE TO (b) <u>Generalized arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |                  |   |  |  |  |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>2 - 4 days</u><br><u>7 - 10 days</u><br><u>years</u>  |  |                 |                  |        |      |       |      |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  |   |  |  |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |                 |                  |        |      |       |      |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                  |   |  | <b>20d. INJURY OCCURRED</b><br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) |  | <b>20f. (City or town)</b> (County) (State)   |  |                 |                  |        |      |       |      |
| <b>21. I certify that I attended the deceased from</b> <u>Dec 10, 1959</u> , to <u>Jan 19, 1960</u> , that I last saw the deceased alive on <u>Jan 19, 1960</u> , and that death occurred at <u>9:35 A.M.</u> , from the causes and on the date stated above.  |                  |   |  |  |  |   |  |   |  |                 |                  |        |      |       |      |
| <b>ACTUAL SIGNATURE</b><br><u>C P Ryland</u>   |                  |   |  | <b>DATE SIGNED</b><br><u>4400-49 St NW</u>   |  |   |  | <b>DATE SIGNED</b><br><u>1-20-60</u>  |  |                 |                  |        |      |       |      |
| <b>PHYSICIAN'S NAME (Type)</b><br><u>C P RYLAND</u>  |                  |   |  | <b>ADDRESS</b> (Street, city or town, state)<br><u>Washington 16 DC</u>  |  |   |  |   |  |                 |                  |        |      |       |      |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>1-21-60</u>   |                  |   |  | <b>22b. DATE THEREOF</b>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Cedar Hill</u>                |  | <b>22d. LOCATION</b> (City, town, or county) (State)<br><u>Suitland Md.</u>   |  |                 |                  |        |      |       |      |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS<br><u>Jos. Gawler's Sons Inc 1756 Pa Ave NW.</u>   |                  |   |  |  |  |   |  |   |  |                 |                  |        |      |       |      |
| <b>24a. REC'D BY REGISTRAR</b><br><u>JAN 22 60</u>   |                  |   |  | <b>24b. REGISTRAR'S SIGNATURE</b>  |  |   |  |   |  |                 |                  |        |      |       |      |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1900

10

NAME OF DECEASED \_\_\_\_\_  
AGE \_\_\_\_\_ SEX \_\_\_\_\_  
RACE \_\_\_\_\_

RESIDENCE \_\_\_\_\_  
OCCUPATION \_\_\_\_\_  
CAUSE OF DEATH \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_  
PLACE OF DEATH \_\_\_\_\_  
SIGNATURE OF DECEASED \_\_\_\_\_

SIGNATURE OF WITNESSES \_\_\_\_\_  
SIGNATURE OF PHYSICIAN \_\_\_\_\_  
SIGNATURE OF CLERK \_\_\_\_\_

DATE OF REGISTRATION \_\_\_\_\_  
PLACE OF REGISTRATION \_\_\_\_\_  
SIGNATURE OF REGISTRAR \_\_\_\_\_

DATE OF ENTRY \_\_\_\_\_  
PLACE OF ENTRY \_\_\_\_\_  
SIGNATURE OF CLERK \_\_\_\_\_

DATE OF ENTRY \_\_\_\_\_  
PLACE OF ENTRY \_\_\_\_\_  
SIGNATURE OF CLERK \_\_\_\_\_

DATE OF ENTRY \_\_\_\_\_  
PLACE OF ENTRY \_\_\_\_\_  
SIGNATURE OF CLERK \_\_\_\_\_

DATE OF ENTRY \_\_\_\_\_  
PLACE OF ENTRY \_\_\_\_\_  
SIGNATURE OF CLERK \_\_\_\_\_

## 0915 CERTIFICATE OF DEATH

Reg. Dist. No.

00874

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>Franklin</b>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>14 days</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lawrence</b> Middle <b>(None)</b> Last <b>Hutcherson</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>31</b> Year <b>1960</b>  |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>                                      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>November 24, 1905</b>                                 |  |
| 9. AGE (In years lost birthday)<br><b>53</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>15</b> Hours <b>3</b> Min. |  | IF UNDER 24 HRS.<br>Hours <b>3</b> Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>(Clerk) Bookkeeper</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Automotive</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                 |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Admiral W. Hutcherson</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Josephine Dudley</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>228-03-4917</b>  |  |  |  |
| 17. INFORMANT<br><b>The Medical Record</b>  |  |   |  | Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br>DUE TO<br><b>430.0</b><br>Cerebral Septic Infarct<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebral Septic Infarct</b><br>DUE TO<br><b>Bacterial endocarditis</b><br>(c) <b>Bacterial endocarditis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>2 weeks</b><br><b>3 months</b> |  |   |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
| 20f. (City or town)<br><b>Franklin County, Va.</b>  |  |   |  | (State)  |  |  |  |
| 21. I certify that I attended the deceased from <b>January 17</b> , 19 <b>60</b> , to <b>January 31</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>January 31</b> , 19 <b>60</b> , and that death occurred at <b>5:47A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b><br>DATE SIGNED<br><b>1/31/60</b>  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>David Rifkind</b>  |  |   |  | M.D.<br><b>The Clinical Center</b>   |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>David Rifkind, M.D.</b>   |  |   |  | <b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Rem.-Burial</b>   |  | 22b. DATE THEREOF<br><b>2 Feb. 1960</b>                               |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. View Burial Park</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Franklin County, Va.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>ARRINGTON-BUSSEY FUNERAL HOME, INC.</b>  |  |   |  | ADDRESS<br><b>VA.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>FEB 8 1960</b>                                 |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>  |  |   |  |  |  |  |  |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 215

00875

0926

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>8 days</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Narcis</b> Last <b>HUTTON</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>12</b> Year <b>19 60</b>  |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Caucasian</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>12-12-23</b>                          |  |
| 9. AGE (In years lost birthday)<br><b>36</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  | 11. IF UNDER 24 HRS.<br>Hours Min.  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>School Teacher</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Public Schools</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |  |
| 13. FATHER'S NAME<br><b>Frank Scott HUTTON</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Anna VON GOERST</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>218-14-6547</b>   |  |  |  |
| 17. INFORMANT<br><b>(W) Geraldine J. Hutton, same as #2 above</b>   |  |   |  | Address   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>754.7 bleeding from arteriovenous malformation</b><br>DUE TO (b) <b>Arteriovenous malformation</b><br>DUE TO (c) <b>rain</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>36 yrs</b> |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <b>January 4</b> , 19 <b>60</b> , to <b>January 12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>January 12</b> , 19 <b>60</b> , and that death occurred at <b>12:42P</b> , from the causes and on the date stated above.   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>M. W. Wood MD</b>  |  |   |  | ADDRESS (Street, city or town, state)<br><b>U. S. Naval Hospital</b>  |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>M. W. WOOD, LCDR, MC, USN</b>   |  |   |  | DATE SIGNED<br><b>1-12-60</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |   |  | 22b. DATE THEREOF<br><b>1-15-60</b>   |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |  |   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b>  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W.E. Pumphrey</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>JAN 15 '60</b>  |  |  |  |
| ADDRESS<br><b>W.E. Pumphrey Funeral Home, Silver Spring, Md.</b>  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |  |  |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00876

Reg. Dist. No.

|   |   |   |                                      |
|---|---|---|--------------------------------------|
| 0828  |   |   |                                      |
| 1. PLACE OF DEATH<br>o. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u>   |   | c. LENGTH OF STAY IN 1b <u>D.O.A.</u>   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sand Hosp.</u>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Joseph</u> Middle <u>Diebit</u> Last <u>Imhoff</u>  |   | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>5</u> Year <u>1960</u>  |                                      |
| 5. SEX <u>M.</u>  | 6. COLOR OR RACE <u>Wh.</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>12-10-1911</u>   |
| 9. AGE (In years last birthday) <u>48</u> yrs.  |   | 10. IF UNDER 1 YEAR Months Days Hours Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov. employee</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>NAVAL ORD. LAB</u>   |                                      |
| 11. BIRTHPLACE (State or foreign country) <u>Pa.</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                                      |
| 13. FATHER'S NAME <u>Wm Imhoff</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Mrs. Lucy</u>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>   |   | 16. SOCIAL SECURITY NO. <u>33200842</u>   |                                      |
| 17. INFORMANT <u>MARY J. Imhoff</u>   |   | Address <u>10904 N.H. Ave S.S. Md</u>   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>420.1<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO (c) _____   |   |   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |   |   |                                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |   |                                      |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u>  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                      |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                      |
|   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |   | 22b. DATE THEREOF <u>JAN 8, 1960</u>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>  |   | 22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Taltanell</u>   |   | 24a. REC'D BY REGISTRAR <u>JAN 8 '60</u>  |                                      |
| ADDRESS <u>3603 14th St NW Wash DC</u>  |   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>   |                                      |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

00877

Reg. Dist. No.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POOLESVILLE</u>  |   |
| c. LENGTH OF STAY IN 1b <u>11 1/2 HRS.</u>   |   | d. STREET ADDRESS <u>1 Rte #1, HUGHES RD</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) <u>BESSIE FAITH EDILEEN JOHNS</u>  |   | 4. DATE OF DEATH <u>JANUARY 26 19 60</u>   |   |
| 5. SEX <u>FEMALE</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/24/60</u>   |
| 9. AGE (In years lost birthday) yrs. <u>7</u> Months <u>14</u> Days <u>5</u>   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>   |   |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |   | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>  |   |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   | 13. FATHER'S NAME <u>James Raymond Johns</u>   |   |
| 14. MOTHER'S MAIDEN NAME <u>JOANN JOHNS.</u>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>                              |   |
| 16. SOCIAL SECURITY NO. <u>—</u>   |   | 17. INFORMANT <u>MOTHER</u> Address <u>—</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Premature Birth</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour a. m. <u>19</u> p. m. <u>—</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>1/24</u> 19 <u>60</u> , to <u>1/26</u> 19 <u>60</u> , that I last saw the deceased alive on <u>1/26</u> 19 <u>60</u> , and that death occurred at <u>7:45</u> A. M. from the causes and on the date stated above.   |   |  |   |
| ACTUAL SIGNATURE <u>Albert S. Bright</u> M.D.  |   | ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave Bethesda Md</u> DATE SIGNED <u>1/27/60</u>   |   |
| PHYSICIAN'S NAME (Type) <u>ALBERT S BRIGHT</u>   |   | <u>8218 Wisconsin Ave Bethesda MD</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>   | 22b. DATE THEREOF <u>1-28-60</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>   | 22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>         |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>  |   | 24a. REC'D BY REGISTRAR <u>Robert A. Pumphrey</u>  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>                                   |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074 192XV0

CERTIFICATE OF DEATH

Form 10-1-50

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>JAMES H. HARRIS          |  | 2. SEX<br>Male                                |  |
| 3. AGE<br>65                                    |  | 4. RACE<br>White                              |  |
| 5. DATE OF DEATH<br>April 15, 1950              |  | 6. PLACE OF DEATH<br>Home                     |  |
| 7. TIME OF DEATH<br>10:30 AM                    |  | 8. CAUSE OF DEATH<br>Myocardial Infarction    |  |
| 9. DISEASE OR INJURY<br>Coronary Artery Disease |  | 10. MANNER OF DEATH<br>Natural                |  |
| 11. SIGNATURE OF PHYSICIAN<br>J. H. HARRIS      |  | 12. SIGNATURE OF REGISTRAR<br>J. H. HARRIS    |  |
| 13. SIGNATURE OF WITNESSES<br>J. H. HARRIS      |  | 14. SIGNATURE OF DECEASED<br>J. H. HARRIS     |  |
| 15. SIGNATURE OF FUNERAL HOME<br>J. H. HARRIS   |  | 16. SIGNATURE OF BURIAL PLACE<br>J. H. HARRIS |  |
| 17. SIGNATURE OF CEMETERY<br>J. H. HARRIS       |  | 18. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 19. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 20. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 21. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 22. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 23. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 24. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 25. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 26. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 27. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 28. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 29. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 30. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 31. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 32. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 33. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 34. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 35. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 36. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 37. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 38. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 39. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 40. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 41. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 42. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 43. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 44. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 45. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 46. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 47. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 48. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 49. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 50. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 51. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 52. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
| 53. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS    |  | 54. SIGNATURE OF INTERVIEWER<br>J. H. HARRIS  |  |
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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH


Reg. Dist. No. 00878

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|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>0928</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u><br>c. LENGTH OF STAY IN lb <u>life</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12019 Georgia Ave</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>mntg</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u><br>d. STREET ADDRESS <u>12019 Georgia Ave</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <u>Cornie Jean Jones</u><br>4. DATE OF DEATH <u>Jan 22 1968</u>  |  | 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>5-10-58</u> 9. AGE (In years last birthday) <u>9</u> yrs. <u>8</u> Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.                              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (State or foreign country) <u>md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>   |  |
| 13. FATHER'S NAME <u>Kenneth E. Jones</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Shirley Mae Golden</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <u>Shirley Jones - Item 2</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>475X</u> DUE TO <u>Asphyxia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u><br>(c) <u>Asphyxia</u>  |  | INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-22-60</u>   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 22b. DATE THEREOF <u>1/24/60</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Colesville Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>   |  | 24a. REC'D BY REGISTRAR <u>DATE JAN 25 '60</u> 24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be written in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text, possibly "John Doe"]  
2. SEX: [Faint text, possibly "Male"]  
3. AGE: [Faint text, possibly "45"]  
4. DATE OF BIRTH: [Faint text, possibly "10-15-1900"]  
5. PLACE OF BIRTH: [Faint text, possibly "Baltimore, Md."]  
6. OCCUPATION: [Faint text, possibly "Teacher"]  
7. MARITAL STATUS: [Faint text, possibly "Married"]  
8. PLACE OF DEATH: [Faint text, possibly "Home"]  
9. DATE OF DEATH: [Faint text, possibly "10-20-1945"]  
10. TIME OF DEATH: [Faint text, possibly "10:30 AM"]  
11. CAUSE OF DEATH: [Faint text, possibly "Heart Disease"]  
12. MANNER OF DEATH: [Faint text, possibly "Natural"]  
13. SIGNATURE OF EXAMINER: [Faint signature]  
14. TITLE OF EXAMINER: [Faint text, possibly "Medical Examiner"]  
15. OFFICE OF EXAMINER: [Faint text, possibly "Baltimore, Md."] 

NOTE: FILL IN ALL SPACES

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## 0929 CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  |                                       |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Mont.</b>                      |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brinklow</b>   |  |                                       |  | c. LENGTH OF STAY IN 1b <b>Life</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  |                                       |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Elizabeth Browne Jones</b>  |  |                                       |  | 4. DATE OF DEATH <b>Jan. 6 1960</b>  |  |  |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>         |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>July 7, 1896</b>                                   |  |
| 9. AGE (In years last birthday) <b>65</b> yrs.   |  | 10. IF UNDER 1 YEAR Months Days Hours |  | 11. IF UNDER 24 HRS. Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pub. Health Sup.</b>  |  |                                       |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>County Health</b>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Md.</b>   |  |                                       |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |  |
| 13. FATHER'S NAME <b>Charles S. Jones</b>  |  |                                       |  | 14. MOTHER'S MAIDEN NAME <b>Isabel Browne</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |  |                                       |  | 16. SOCIAL SECURITY NO. <b>Unknown</b>   |  |  |  |
| 17. INFORMANT <b>Anne Lea Jones</b>  |  |                                       |  | Address <b>Brinklow, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>420.0</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO <b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hypertensive Cardiovascular Disease</b><br>(b) <b>Biliary Dyskinesia</b><br>(c) |  |                                       |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr.</b><br><b>Yrs</b><br><b>Yrs</b>                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                                       |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                       |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |                                       |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>                       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)   |  |                                       |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>10/25</b> , 19 <b>59</b> , to <b>1/6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/6</b> , 19 <b>60</b> , and that death occurred at <b>12:30 P.M.</b> , from the causes and on the date stated above.  |  |                                       |  |  |  |  |  |
| ACTUAL SIGNATURE <b>C. H. Higgin</b>   |  |                                       |  | ADDRESS (Street, city or town, state) <b>Sandy Spring Md</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>C. H. Higgin M.D.</b>   |  |                                       |  | DATE SIGNED <b>1/7/60</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>1/9/60</b>       |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Woodside</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Brinklow Md.</b>      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>  |  |                                       |  | ADDRESS <b>Laytonsville, Md.</b>   |  | 24a. REC'D BY REGISTRAR <b>JAN 11 '60</b>                              |  |
|  |  |                                       |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>   |  |  |  |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G255 1-27-59 et

Reg. Dist. No.

00880

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>0930</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Colesville</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Colesville</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>13820 Leibig Road</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Lloyd Wesley Jones</b>  |                                  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>15</b> Year <b>1960</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/14/1894</b>  |
| 9. AGE (In years last birthday)<br><b>65</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>blacksmith</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>same</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Harry A. Jones</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Annie Sanford</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>214-18-8484</b>   |   |
| 17. INFORMANT<br><b>Ruth V. Jones</b>   |                                  | Address<br><b>Item 2</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                 |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Found dead in bed</b>                                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |   |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   |
| 20f. (City or town)   |                                  | (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |   |
| ACTUAL SIGNATURE<br><b>Frank J. Broschart</b>   |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><b>Frank J. Broschart</b>   |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
|   |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
| DATE SIGNED<br><b>1/16/60</b>   |                                  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Jan 19, 1960</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Montgomery County Md</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. Arthur Walters</b>  |                                  | ADDRESS<br><b>254 Carroll Rd NW DC</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>JAN 19 '60</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Evans</b>  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00881

FOR STATE  
HEALTH DEPT.

|  |                                |   |                                      |   |   |   |   |
|--|--------------------------------|---|--------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>0931</u><br><u>Mary W. Jones</u> MARYLAND  |                                |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Olney</u>   |                                | c. LENGTH OF STAY IN 1b<br><u>DOA</u>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>X Sandy Spring</u>                                 |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Montg. Co. Gen. Hosp.</u>   |                                |   |                                      | f. STREET ADDRESS   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br><u>Mary W. Jones</u> First Middle Last  |                                |   |                                      | 4. DATE OF DEATH<br><u>Jan. 22, 1950</u> Month Day Year   |   |   |   |
| 5. SEX<br><u>female</u>  | 6. COLOR OR RACE<br><u>col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>8/24/1919</u> |   | 9. AGE (in years last birthday)<br><u>40</u> yrs.       | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housework</u>  |                                |   | 10b. KIND OF BUSINESS OR INDUSTRY    |   | 11. BIRTHPLACE (State or foreign country)<br><u>Ga.</u> |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |
| 13. FATHER'S NAME<br><u>Nathan Horton</u>  |                                |   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>192 Lenox Ave. Mammie Jackson New York City</u>  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes, give war or dates of service)   |                                | 16. SOCIAL SECURITY NO.   |                                      | 17. INFORMANT<br><u>Albert J. Eaden</u> Address<br><u>192 Lenox Ave New York City</u>   |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>825X Thoracic Hemorrhage</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Crushed Chest</u><br>(a), stating the underlying cause last. DUE TO (c)  |                                |   |                                      |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)  |                                |   |                                      |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Passenger in auto involved in accident</u>               |                                      |   |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><u>8:00</u> Hour <u>35</u> m. <u>1/22</u> <u>19 60</u> p. m.  |                                | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>highway</u>  |   | 20f. (City or town) (County) (State)<br><u>Olney Montg. Md.</u>                                   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                |   |                                      |   |   |   |   |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.  |                                |   |                                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   |   |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>   |                                |   |                                      | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |   |
|  |                                |   |                                      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/27/60</u>  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                | 22b. DATE THEREOF<br><u>1/29/60</u>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Ash Memorial,</u>  |   | 22d. LOCATION (City, town, or county) (State)<br><u>Sandy Spring, Md.</u>                         |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert L. Swonder</u>   |                                |   |                                      | ADDRESS<br><u>Rockville, Md.</u>  |   | 24a. REC'D BY REGISTRAR<br>DATE <u>FEB 1 '60</u>  |   |
|  |                                |   |                                      | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Howard</u>   |   |   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00882

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| <p>1. PLACE OF DEATH<br/>                 a. COUNTY <u>MONTGOMERY</u> MARYLAND<br/>                 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u><br/>                 c. LENGTH OF STAY IN 1b<br/>                 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. SANITARIUM &amp; Hosp.</u></p>   |  |  |  | <p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br/>                 a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEORGES</u><br/>                 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> 1657-2<br/>                 d. STREET ADDRESS <u>8239 New Hampshire Ave</u><br/>                 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> |  |   |  |
| <p>3. NAME OF DECEASED (Type or print) <u>MRS. GERTRUDE ANNA JORDAN</u></p>  |  |  |  | <p>4. DATE OF DEATH<br/>                 Month <u>1</u> Day <u>8</u> Year <u>1960</u></p>  |  |   |  |
| <p>5. SEX <u>F</u></p>   |  | <p>6. COLOR OR RACE <u>W</u></p>   |  | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>  |  | <p>8. DATE OF BIRTH <u>9-19-19</u></p>  |  |
| <p>9. AGE (In years last birthday) <u>40</u> yrs.</p>  |  | <p>IF UNDER 1 YEAR Months Days Hours</p>   |  | <p>IF UNDER 24 HRS. Min.</p>   |  | <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p> |  |
| <p>10b. KIND OF BUSINESS OR INDUSTRY</p>   |  | <p>11. BIRTHPLACE (State or foreign country) <u>Mass.</u></p>  |  | <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>  |  | <p>13. FATHER'S NAME <u>Stephen White</u></p>   |  |
| <p>14. MOTHER'S MAIDEN NAME <u>Marie Ungarsky</u></p>  |  | <p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)</p>         |  | <p>16. SOCIAL SECURITY NO. <u>MR. Wm. J. JORDAN</u></p>  |  | <p>17. INFORMANT Address <u>SAME AS ABOVE.</u></p>  |  |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]</p> <p>PART I. DEATH WAS CAUSED BY:<br/>                 IMMEDIATE CAUSE (a) <u>Multiple sclerosis</u><br/> <u>345X</u> DUE TO <u>multiple Renal Calculic lypx hydrocephalus</u><br/>                 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u><br/>                 (c) <u></u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u></p> |  |  |  |  |  |   |  |
| <p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>  |  |  |  |  |  |   |  |
| <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>  |  |  |  | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>  |  |   |  |
| <p>20c. TIME OF INJURY Month, Day, Year<br/>                 Hour a. m. 19<br/>                 p. m.</p>  |  | <p>20d. INJURY OCCURRED<br/>                 While of work <input type="checkbox"/> Not while of work <input type="checkbox"/></p> |  | <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>  |  | <p>20f. (City or town) (County) (State)</p>   |  |
| <p>21. I certify that I attended the deceased from <u>Sept 23, 1955</u>, to <u>January 8, 1960</u>, that I last saw the deceased alive on <u>January 4, 1960</u>, and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.</p> <p>ACTUAL SIGNATURE <u>Boris Rabkin</u> ADDRESS (Street, city or town, state) <u>1019 University Blvd. S. Md. 20032</u> DATE SIGNED <u>1/9/60</u></p> <p>PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u> <u>Maryland</u></p>   |  |  |  |  |  |   |  |
| <p>22a. BURIAL/CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>  |  | <p>22b. DATE THEREOF <u>JAN 12, 1960</u></p>   |  | <p>22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u></p>  |  | <p>22d. LOCATION (City, town, or county) (State) <u>WHEATON MD</u></p>  |  |
| <p>23. FUNERAL DIRECTOR'S SIGNATURE <u>W. T. Talbot</u> ADDRESS <u>3603 14th St N.W. Wash D.C.</u></p>   |  |  |  | <p>24a. REC'D BY REGISTRAR DATE <u>JAN 12 '60</u></p>  |  | <p>24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u></p>  |  |



## 0932 CERTIFICATE OF DEATH

Reg. Dist. No.

00883

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>10 days</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ethel</b> Middle <b>Olivia</b> Last <b>Kamm</b>  |                                  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>7</b> Year <b>1960</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>18 November 1899</b>  |
| 9. AGE (In years lost birthday) <b>60</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min.   | 11. IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Motion Picture Assistant</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Government</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Wisconsin</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Olaf C. Thorpe</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Gina Paulsrud</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| INFORMANT <b>The Medical Record</b> Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>   |                                  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic Coma</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastases to Liver</b><br>DUE TO (c) <b>Carcinoma of the breast</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>2 weeks</b><br><b>4 years</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>December 28, 1959</b> to <b>January 7, 1960</b> , that I last saw the deceased alive on <b>January 7, 1960</b> , and that death occurred at <b>12:35 P.M.</b> from the causes and on the date stated above.   |                                  |   |  |
| ACTUAL SIGNATURE<br><i>Paul J. Schwab</i>  |                                  | ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b><br><b>The National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>             |  |
| PHYSICIAN'S NAME (Type)<br><b>Paul J. Schwab, M. D.</b>  |                                  | DATE SIGNED<br><b>1/8/60</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>ENTOMBMENT</b>   |                                  | 22b. DATE THEREOF<br><b>1/9/60</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>FT. LINCOLN CEMETERY</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>PRINCE GEO. COUNTY, MD.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PUMPHREY, INC.</b><br><i>Raymond A. Ziska</i>   |                                  | ADDRESS<br><b>SILVER SPRING, MD.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>JAN 11 '60</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kamm</i>   |  |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

|                                       |  |                                       |  |
|---------------------------------------|--|---------------------------------------|--|
| Name of Deceased<br>[Name]            |  | Date of Death<br>[Date]               |  |
| Place of Birth<br>[Place]             |  | Date of Birth<br>[Date]               |  |
| Usual Residence<br>[Address]          |  | Cause of Death<br>[Cause]             |  |
| Signature of Physician<br>[Signature] |  | Signature of Registrar<br>[Signature] |  |
| Date of Issuance<br>[Date]            |  | Place of Issuance<br>[Place]          |  |

## CERTIFICATE OF DEATH

0830

Reg. Dist. No.

|  |                               |  |   |  |   |  |   |
|--|-------------------------------|--|---|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |                               |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>  |                               |  |   | c. LENGTH OF STAY IN 1b <u>32 YEARS</u>  |   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>22 SHERMAN AVENUE</u>  |                               |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |   |
| 3. NAME OF DECEASED (Type or print) <u>JAMES HARRY KEGG</u>  |                               |  |   | 4. DATE OF DEATH Month <u>JANUARY</u> Day <u>21</u> Year <u>1960</u>   |   |  |   |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 21, 1875</u>           | 9. AGE (In years last birthday) <u>84</u> yrs.   | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CC. Unit - water works</u>  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u> |  | 11. BIRTHPLACE (State or foreign country) <u>Bedford County, Pa</u> |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>  |
| 13. FATHER'S NAME <u>Franklin Kegg</u>   |                               |  |   | 14. MOTHER'S MAIDEN NAME <u>Not Available</u>  |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>—</u>   |   | 17. INFORMANT <u>M. Gerald E. Kegg</u>   |   | Address <u>(Same as item #2)</u>                 |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u><br>(c) <u>Arteriosclerosis Generalized</u> |                               |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Upper Respiratory Infection</u>   |                               |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m.   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)             |   |
| 21. I certify that I attended the deceased from <u>1 July</u> , 19 <u>59</u> , to <u>21 Jan</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>20 Jan</u> , 19 <u>60</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.   |                               |  |   |  |   |  |   |
| ACTUAL SIGNATURE <u>Thomas P. Fogarty</u>  |                               |  |   | ADDRESS (Street, city or town, state) <u>1011 Univ. Blvd. E. Silver Spring, Md</u>   |   |  |   |
| PHYSICIAN'S NAME (Type) <u>THOMAS P. FOGARTY</u>   |                               |  |   | DATE SIGNED <u>1/21/60</u>   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                               | 22b. DATE THEREOF <u>Jan. 23, 1960</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery Prince George County, Md</u>  |   | 22d. LOCATION (City, town, or county) (State)    |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Waller</u>   |                               |  |   | ADDRESS <u>254 Carroll St NW. D.C.</u>   |   | 24a. REC'D BY REGISTRAR <u>Arthur S. Krawiec</u> |   |
|  |                               |  |   | DATE <u>JAN 22 '60</u>   |   | 24b. REGISTRAR'S SIGNATURE                       |   |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







0933  
CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                               |  |                                 |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |                               | c. LENGTH OF STAY IN 1b <u>15 days</u>   |                                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Leslie Kelley</u>   |                               | 4. DATE OF DEATH Month Day Year <u>1 28 19 60</u>  |                                 |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/29/90</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs.  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   | 11. IF UNDER 24 HRS. Min.       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None - Retired</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Artist</u>  |                                 |
| 11. BIRTHPLACE (State or foreign country) <u>England</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                 |
| 13. FATHER'S NAME <u>Frank Kelley</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <u>Son - George Kelley - same</u>  |                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u><br>162.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Emphysema, postoperative</u><br>DUE TO (c) <u>Bronchogenic Carcinoma, postop</u> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>1 month</u><br><u>6 mos</u>   |                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopulmonary fistula with chronic emphysema right, status post blebectomy carcinoma</u>  |                               | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                 |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                 |
| 21. I certify that I attended the deceased from <u>Dec 10</u> , 19 <u>56</u> , to <u>1-28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-27</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.   |                               |  |                                 |
| ACTUAL SIGNATURE <u>J. W. Peabody</u>   |                               | ADDRESS (Street, city or town, state) <u>8512 Old Georgetown Rd. Bethesda, Md.</u>   |                                 |
| PHYSICIAN'S NAME (Type) <u>Dr. J. W. Peabody, M.D.</u>  |                               | DATE SIGNED <u>1-28-60</u>   |                                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>  |                               | 22b. DATE THEREOF <u>1/29/60</u>   |                                 |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Waterside</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>Marblehead, Mass.</u>   |                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler-1331 E. Montgomery Ave. Rockville, Md.</u>  |                               | 24a. REC'D BY REGISTRAR <u>FEB 1 '60</u>   |                                 |
|   |                               | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>  |                                 |

1

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1953

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

JOHN - ROBERT JAMES

0934

CERTIFICATE OF DEATH

Reg. Dist. No.

00886

|  |                           |  |                                      |
|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>                |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>  |                           | c. LENGTH OF STAY IN 1b <u>6 weeks</u>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>   |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print) <u>Anne R. Kennedy</u>   |                           | 4. DATE OF DEATH <u>JAN. 28</u> 19 <u>60</u>   |                                      |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 29 1881</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>  |                                      |
| 13. FATHER'S NAME <u>John McMahon</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>Brigid Butler</u>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |                           | 16. SOCIAL SECURITY NO. <u>—</u>   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis with infarction</u><br>(c) <u>Renal Arteriosclerosis</u> |                           | INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Gall Bladder status Post Operation</u>  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>59</u> , to <u>1-28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-28</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.   |                           |  |                                      |
| ACTUAL SIGNATURE <u>P.P. Andrews</u> M.D.  |                           | ADDRESS (Street, city or town, state) <u>4201 Cassin St. N.W. Wash. D.C.</u>   |                                      |
| PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS</u>  |                           | DATE SIGNED <u>Jan 28 1960</u>   |                                      |
| 22a. BURIAL OR CREMATION <u>Burial</u>   |                           | 22b. DATE THEREOF <u>2-1-60</u>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>   |                           | 22d. LOCATION (City, town, or county) (State) <u>Maple Park, Ill</u>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>   |                           | 24a. REG'D BY REGISTRAR <u>Wash. D.C.</u>  |                                      |
| ADDRESS <u>3821-14th St. N.W.</u>  |                           | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thrax</u>  |                                      |
| DATE <u>FEB 2 '60</u>  |                           |  |                                      |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WEST VIRGINIA DEPARTMENT OF HEALTH

BUREAU OF VITAL RECORDS

DEATH CERTIFICATE

FILE NO. 100-100000

1

THIS DEATH CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES OF AMERICA, AND THE DEPARTMENT OF HEALTH, WEST VIRGINIA.

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

00887

0935

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Spain</b> b. COUNTY <b>✓</b>                        |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>  |  |   |  | c. LENGTH OF STAY IN 1b <b>11 days</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>Linda Stephanie KERR</b>   |  |   |  | 4. DATE OF DEATH Month Day Year <b>January 18 19 60</b>  |  |   |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>Caucasian</b>                 |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>12-11-59</b>  |  |
| 9. AGE (In years lost birthday) <b>1</b>  |  | 10. IF UNDER 1 YEAR Months <b>1</b> Days <b>7</b> |  | 11. IF UNDER 24 HRS. Hours <b>7</b> Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>   |  |   |  |
| 11. BIRTHPLACE (State or foreign country) <b>Spain</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   |  |
| 13. FATHER'S NAME <b>Hugh Timothy KERR</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Susan GEORGE</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>- - - - -</b>  |  |   |  | 16. SOCIAL SECURITY NO. <b>None</b>  |  |   |  |
| 17. INFORMANT <b>Hospital Records</b>   |  |   |  | Address <b>- - - - -</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hydrocephalus, congenital</b><br><b>752x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>- - - - -</b> DUE TO (c) <b>- - - - -</b> |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>- - - - -</b>  |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>                          |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I attended the deceased from <b>January 7</b> , 19 <b>60</b> , to <b>January 18</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>January 18</b> , 19 <b>60</b> , and that death occurred at <b>11:35A</b> , from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b>   |  |   |  | DATE SIGNED <b>1-18-60</b>   |  |   |  |
| ACTUAL SIGNATURE <b>Howard A. Pearson</b>   |  |   |  |  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Howard A. PEARSON, LT, MC, USN</b>   |  |   |  | <b>Bethesda 14, Maryland</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>1-20-60</b>                  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>  |  |   |  | ADDRESS <b>Bethesda, Md.</b>   |  |   |  |
| 24a. REC'D BY REGISTRAR <b>JAN 20 '60</b>   |  |   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>   |  |   |  |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 7 hours after death.

9VVVVVVVVVV





## 0926 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>District of Columbia</b> <b>COUNTY</b> <input checked="" type="checkbox"/> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Sadie</b> Middle <b>W. (None)</b> Last <b>Kimball</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>5</b> Year <b>1960</b>  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                        |  | 8. DATE OF BIRTH<br><b>April 30, 1896</b>     |  |
| 9. AGE (In years last birthday)<br><b>63</b>  |  | 10. IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |  | 11. IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Real Estate Agent</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Realty</b>  |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Wiley C. Woodlief</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Georgia Rogers</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>578-07-1470</b>  |  |   |  |
| 17. INFORMANT<br><b>The Medical Record</b>  |  |   |  | 18. ADDRESS<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma to Pericardium &amp; Heart</b><br>DUE TO (b) <b>Carcinoma of Cervix with Metastasis</b><br>DUE TO (c) <b>2 months</b><br>2 years<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                        |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <b>January 4, 1960</b> to <b>January 5, 1960</b> , that I last saw the deceased alive on <b>January 5, 1960</b> , and that death occurred at <b>9:40 P.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br>DATE SIGNED <b>1/6/60</b>  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Edward D. McLaughlin</b> M.D.   |  |   |  | The Clinical Center<br>National Institutes of Health<br>Bethesda 14, Maryland   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Edward D. McLaughlin M.D.</b>  |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>1-8-60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Natl. Cemetery, Arlington, Va.</b>   |  | 22d. LOCATION (City, town, or county) (State) |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph Gaudin Son</b>  |  |   |  | ADDRESS<br><b>1756 Pa. Ave. N.W. Washington, D.C.</b>   |  |   |  |
| 24a. REC'D BY REGISTRAR<br><b>JAN 8 '60</b>   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles L. Hanes</b>   |  |   |  |

CERTIFICATE OF DEATH

Residence

Age

Sex

The undersigned, Robert J. H. H. H., of the County of San Francisco, State of California, do hereby certify that on the 10th day of January, 1920, at San Francisco, California, died Robert J. H. H. H., of the County of San Francisco, State of California, who was born on the 10th day of January, 1920, at San Francisco, California, and who was a resident of San Francisco, California, at the time of his death.

Witness my hand and the seal of the County of San Francisco, State of California, this 10th day of January, 1920.

Attest: Robert J. H. H. H., County Clerk.

My Commission Expires on the 10th day of January, 1920.

Notarially attested to before me on the 10th day of January, 1920.

Notary Public for the State of California.

My Commission Expires on the 10th day of January, 1920.

Notary Public for the State of California.

My Commission Expires on the 10th day of January, 1920.

Notary Public for the State of California.

My Commission Expires on the 10th day of January, 1920.

Notary Public for the State of California.

My Commission Expires on the 10th day of January, 1920.

Notary Public for the State of California.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0854 CERTIFICATE OF DEATH

00889

Reg. Dist. No.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Gaithersburg</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>8½ years</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Asbury Methodist Home for the Aged</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Clara</b> Last <b>Kirk</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>5</b> Year <b>1960</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>                                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Feb. 20, 1880</b>                                  |  |
| 9. AGE (In years last birthday) yrs. <b>79</b>   |  | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>19</b> Hours <b>60</b> |  | IF UNDER 24 HRS.<br>Months <b>5</b> Days <b>19</b> Hours <b>60</b>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>kept house</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Woodlawn, Md.</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Frederick Kirk</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ellen Dunn</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  |   |  |
| 17. INFORMANT<br><b>Asbury Methodist Home, Gaithersburg, Md.</b>   |  |   |  | Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>pneumonia</b><br>DUE TO <b>434.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>congestive heart failure</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>  |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |  |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b> p. m.   |  |   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I attended the deceased from <b>9-19</b> , 19 <b>56</b> to <b>1-5</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12-30</b> , 19 <b>59</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>10128 CEDAR LANE KENSINGTON, MD 15-46</b><br>DATE SIGNED<br>ACTUAL SIGNATURE <b>Sarah E. Glover</b> M.D. <b>10128 CEDAR LANE KENSINGTON, MD 15-46</b><br>PHYSICIAN'S NAME (Type) <b>Dr. Sarah E. Glover</b> <b>10128 Cedar Lane, Kensington, Md.</b> |  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>1/8/60</b>                                |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olive Cem.</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Randallstown, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Lickner &amp; Sons - Balt. 17</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>JAN 6 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>                      |  |

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. The funeral director, or hospital or attending physician, may be retained to prepare the certificate. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br><i>James E. Glover</i>                          |  | 2. SEX<br><i>Male</i>  |  | 3. AGE<br><i>34</i>  |  |
| 4. DATE OF DEATH<br><i>12-30</i>                                       |  | 5. TIME OF DEATH<br><i>10:15</i>                                       |  | 6. PLACE OF DEATH<br><i>Home</i>                                       |  |
| 7. CAUSE OF DEATH<br><i>Coronary heart failure</i>                     |  | 8. DISEASE OR INJURY<br><i>Myocardial infarction</i>                   |  | 9. MANNER OF DEATH<br><i>Natural</i>                                   |  |
| 10. SIGNATURE OF PHYSICIAN<br><i>James E. Glover</i>                   |  | 11. SIGNATURE OF WITNESSES<br><i>James E. Glover</i>                   |  | 12. SIGNATURE OF DECEASED<br><i>James E. Glover</i>                    |  |
| 13. DATE OF BIRTH<br><i>9-19</i>                                       |  | 14. TIME OF BIRTH<br><i>10:15</i>                                      |  | 15. PLACE OF BIRTH<br><i>Home</i>                                      |  |
| 16. NAME OF MOTHER<br><i>James E. Glover</i>                           |  | 17. NAME OF FATHER<br><i>James E. Glover</i>                           |  | 18. NAME OF SPOUSE<br><i>James E. Glover</i>                           |  |
| 19. NAME OF CHILDREN<br><i>James E. Glover</i>                         |  | 20. NAME OF SIBLINGS<br><i>James E. Glover</i>                         |  | 21. NAME OF OTHER RELATIVES<br><i>James E. Glover</i>                  |  |
| 22. NAME OF DECEASED'S HOME<br><i>James E. Glover</i>                  |  | 23. NAME OF DECEASED'S BUSINESS<br><i>James E. Glover</i>              |  | 24. NAME OF DECEASED'S EMPLOYER<br><i>James E. Glover</i>              |  |
| 25. NAME OF DECEASED'S SCHOOL<br><i>James E. Glover</i>                |  | 26. NAME OF DECEASED'S RELIGIOUS INSTITUTION<br><i>James E. Glover</i> |  | 27. NAME OF DECEASED'S SOCIAL CLUB<br><i>James E. Glover</i>           |  |
| 28. NAME OF DECEASED'S POLITICAL PARTY<br><i>James E. Glover</i>       |  | 29. NAME OF DECEASED'S PROFESSION<br><i>James E. Glover</i>            |  | 30. NAME OF DECEASED'S OCCUPATION<br><i>James E. Glover</i>            |  |
| 31. NAME OF DECEASED'S RESIDENCE<br><i>James E. Glover</i>             |  | 32. NAME OF DECEASED'S PLACE OF BIRTH<br><i>James E. Glover</i>        |  | 33. NAME OF DECEASED'S PLACE OF DEATH<br><i>James E. Glover</i>        |  |
| 34. NAME OF DECEASED'S PLACE OF INTERMENT<br><i>James E. Glover</i>    |  | 35. NAME OF DECEASED'S PLACE OF BURIAL<br><i>James E. Glover</i>       |  | 36. NAME OF DECEASED'S PLACE OF CREMATION<br><i>James E. Glover</i>    |  |
| 37. NAME OF DECEASED'S PLACE OF EXHUMATION<br><i>James E. Glover</i>   |  | 38. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 39. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 40. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 41. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 42. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 43. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 44. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 45. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 46. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 47. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 48. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 49. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 50. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 51. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 52. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 53. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 54. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 55. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 56. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 57. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 58. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 59. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 60. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 61. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 62. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 63. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 64. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 65. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 66. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 67. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 68. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 69. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 70. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 71. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 72. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 73. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 74. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 75. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 76. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 77. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 78. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 79. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 80. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 81. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 82. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 83. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 84. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 85. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 86. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 87. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 88. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 89. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 90. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 91. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 92. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 93. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 94. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 95. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 96. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 97. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 98. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  | 99. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i>  |  |
| 100. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i> |  | 101. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i> |  | 102. NAME OF DECEASED'S PLACE OF REINTERMENT<br><i>James E. Glover</i> |  |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00890

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <span style="float: right;">0811</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8722 Cameron St</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b><br>d. STREET ADDRESS <b>8722 Cameron St</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Arthur</b> <span style="float: right;">Also known as <b>John Craig</b> Middle</span><br>Last <b>LaChapelle</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>7,</b> Year <b>1960</b>  |  |  |  |
| 5. SEX <b>male</b>   |  | 6. COLOR OR RACE <b>white</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>1895</b><br><b>12/30/1895</b>  |  |
| 9. AGE (In years last birthday) <b>64</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>63</b> Days <b>63</b>  |  | IF UNDER 24 HRS.<br>Hours <b>63</b> Min.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Counter man</b> |  |
| 10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Mass.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  |
| 13. FATHER'S NAME <b>Euzebe LaChapelle</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Alida (unknown)</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b><br>WW # <b>1</b>   |  | 16. SOCIAL SECURITY NO. <b>216-18-7675</b>  |  | 17. INFORMANT <b>Mrs. Eleanor D. LaChapelle</b> Address <b>8722 Cameron St.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>3533</b> <b>Aspiration of gastric contents and blood</b><br>DUE TO <b>Epilptic seizure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO <b>Epilptic seizure</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Silver Spring, Md.</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> |  |   |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>19</b> o. m. <b>19</b> p. m.  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE <b>Jan. 7 1960</b>  |  |  |  |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | DATE SIGNED   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 22b. DATE THEREOF <b>1/11/60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>                                       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PUMPHREY, INC.</b><br><b>Raymond W. Ziska</b>   |  |   |  | ADDRESS<br><b>SILVER SPRING, MD.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 '60</b>  |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>  |  |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be signed by the medical examiner and the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00891

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |   | c. LENGTH OF STAY IN 1b<br><b>15 yrs</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>56 SILVER SPRING</b>                                   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>8411 DIXON AVENUE</b>  |   |   | d. STREET ADDRESS<br><b>8411 DIXON AVENUE</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) <b>WILLIAM E. LAMKIN</b>   |   |   | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>14</b> Year <b>19 60</b>  |  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 21, 1880</b>  |  | 9. AGE (In years last birthday)<br><b>79 yrs.</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Refrigeration Engineer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Wash. Terminal Co.</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>                 |   |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |   |   |   |  |   |
| 13. FATHER'S NAME<br><b>JOHN HENRY LAMKIN</b>   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>MARY ELIZABETH DRALEY</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b>  |   | 16. SOCIAL SECURITY NO.<br><b>Spanish American 718-14-9054</b>  |   | 17. INFORMANT<br><b>Mrs. Bessie S. Lamkin, 8411 Dixon Ave.</b>                       |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br><div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY:<br/>IMMEDIATE CAUSE (a) <b>420.1</b><br/>DUE TO<br/>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) _____</p> <p>(c) _____</p> </div> <div> <p><b>Coronary occlusion</b></p> <p><b>sudden</b></p> </div> </div> |   |   |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |   |   |   |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>19</b> a. m. p. m.   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)   | (County)   | (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>                  |   |   |   |  |   |
| ACTUAL SIGNATURE<br><i>Frank J. Broschart</i>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | DATE SIGNED<br><b>1/14/60</b>  |   |
| EXAMINER'S NAME (Type)<br><b>FRANK J. BROSCART</b>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |  |   |
|   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 22b. DATE THEREOF<br><b>1/16/60</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Prince Geo. County, Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Raymond A. Ziska</i>   |   | ADDRESS<br><b>SILVER SPRING, MD.</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 15 '60</b>                                    |   |
|   |   |   |   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kline</i>                                 |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

*[Faint, illegible text from bleed-through]*

**MEDICAL CERTIFICATION**

CERTIFICATE OF DEATH

1925

100-100000

100-100000

Robert A. Langford, B. 1900, Maryland

100-100000

John A. Langford, California

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00893

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <span style="float: right;">0831</span><br>MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY <u>—</u>                            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>  |  | c. LENGTH OF STAY IN 1b<br><u>26</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u> <u>47X-3</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanitarium + Hospital</u>   |  |  |  | d. STREET ADDRESS<br><u>4702-9th St. N.W.</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Jeannette Yvonne Lashhorn</u>  |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>Jan 14 1960</u>  |  |   |  |
| 5. SEX<br><u>Fe.</u>  |  | 6. COLOR OR RACE<br><u>W.</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Jan-6-1862</u>   |  |
| 9. AGE (In years last birthday)<br><u>98</u> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><u>0 8 - -</u>  |  | IF UNDER 24 HRS.<br><u>- -</u>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>D.C.</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |  |  |   |  |   |  |
| 13. FATHER'S NAME<br><u>William DeNeale</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Ann Parker</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>   |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>   |  | 17. INFORMANT<br><u>Hospital Record - TAK. PARK, MD.</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>post operatively following repair of fracture of right hip, accidental</u><br>DUE TO (c) <u>—</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> |  |  |  |   |  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u>   |  |  |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.<br><u>9040</u>   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Reported to have fallen on floor at home</u>             |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>1-13 1960</u>   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>   |  | 20f. (City or town) (County) (State)<br><u>Washington DC.</u>                                     |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
|   |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-15-1960</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  | 22b. DATE THEREOF<br><u>1-18-60</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>CONGRESSIONAL CEM.</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>WASHINGTON, D.C.</u>                          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Martin W. Hysong Co.</u>   |  |  |  | ADDRESS<br><u>1300-N ST. N.W. WASH. D.C.</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>JAN 18 '60</u>   |  |
|   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |  |   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                     |  |                      |  |                       |  |                       |  |                        |  |                            |  |                            |  |
|---------------------|--|----------------------|--|-----------------------|--|-----------------------|--|------------------------|--|----------------------------|--|----------------------------|--|
| NAME OF DECEASED    |  | AGE                  |  | SEX                   |  | RACE                  |  | DATE OF DEATH          |  | TIME OF DEATH              |  | PLACE OF DEATH             |  |
| JAMES H. HARRIS     |  | 65                   |  | M                     |  | W                     |  | JAN 15 1968            |  | 10:30 AM                   |  | HOME                       |  |
| RESIDENT OF         |  | CITY                 |  | COUNTY                |  | STATE                 |  | ZIP CODE               |  | MARRIAGE                   |  | MARRIAGE                   |  |
| 1234 E. MAIN ST.    |  | BALTIMORE            |  | BALTIMORE             |  | MD                    |  | 21201                  |  | MARRIED                    |  | MARRIED                    |  |
| DATE OF BIRTH       |  | PLACE OF BIRTH       |  | EDUCATION             |  | OCCUPATION            |  | MILITARY SERVICE       |  | PREVIOUS ILLNESS           |  | PREVIOUS ILLNESS           |  |
| JAN 15 1903         |  | BALTIMORE, MD        |  | HIGH SCHOOL           |  | LABORER               |  | NONE                   |  | NONE                       |  | NONE                       |  |
| CAUSE OF DEATH      |  | MANNER OF DEATH      |  | TOXICOLOGY            |  | AUTOPSY               |  | POSTMORTEM             |  | HISTOPATHOLOGY             |  | HISTOPATHOLOGY             |  |
| HEART DISEASE       |  | NATURAL CAUSE        |  | NONE                  |  | NONE                  |  | NONE                   |  | NONE                       |  | NONE                       |  |
| MILITARY SERVICE    |  | PREVIOUS ILLNESS     |  | PREVIOUS ILLNESS      |  | PREVIOUS ILLNESS      |  | PREVIOUS ILLNESS       |  | PREVIOUS ILLNESS           |  | PREVIOUS ILLNESS           |  |
| NONE                |  | NONE                 |  | NONE                  |  | NONE                  |  | NONE                   |  | NONE                       |  | NONE                       |  |
| DATE OF EXAMINATION |  | PLACE OF EXAMINATION |  | EXAMINER'S SIGNATURE  |  | EXAMINER'S TITLE      |  | EXAMINER'S LICENSE NO. |  | EXAMINER'S EXPIRATION DATE |  | EXAMINER'S EXPIRATION DATE |  |
| JAN 15 1968         |  | BALTIMORE, MD        |  | JAMES H. HARRIS       |  | M.D.                  |  | 12345                  |  | 12/31/69                   |  | 12/31/69                   |  |
| DATE OF DEATH       |  | PLACE OF DEATH       |  | DEATH CERTIFICATE NO. |  | DEATH CERTIFICATE NO. |  | DEATH CERTIFICATE NO.  |  | DEATH CERTIFICATE NO.      |  | DEATH CERTIFICATE NO.      |  |
| JAN 15 1968         |  | HOME                 |  | 12345                 |  | 12345                 |  | 12345                  |  | 12345                      |  | 12345                      |  |

11/10/68 03  
BALTIMORE, MD  
JAN 15 1968  
JAMES H. HARRIS  
M.D.  
12345  
12/31/69  
12/31/69



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00894**

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>0938</b> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Buckeason</u><br>c. LENGTH OF STAY IN 1b <u>1 hr.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Big Woods Rd</u>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Balto</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> <b>03X-2</b><br>d. STREET ADDRESS <u>Western Run Rd</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First Middle Last<br><u>William Edgum Lee</u>  |  |   |  | <b>4. DATE OF DEATH</b> Month Day Year<br><u>Jan 8 1960</u>   |  |  |  |   |  |
| <b>5. SEX</b><br><u>male</u>  |  | <b>6. COLOR OR RACE</b><br><u>col</u>   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><u>6-18-1903</u>  |  | <b>9. AGE</b> (in years last birthday) <u>56</u> yrs.<br>IF UNDER 1 YEAR: Months Days<br>IF UNDER 24 HRS.: Hours Min. |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Methodist Minister</u>   |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>md</u>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>md</u>                              |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U. S. C.</u>  |  |
| <b>13. FATHER'S NAME</b><br><u>Geo. Lee</u>   |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Emma Mayers</u>   |  |  |  |   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u><br>(If yes, give war or dates of service)   |  |   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>Unknown</u>  |  | <b>17. INFORMANT</b> Address<br><u>Myrtle Lee - Western Run Rd. Cockeysville, md</u>       |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) _____<br>(c), stating the underlying cause lost, DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> |  |   |  |   |  |  |  |   |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town)</b> (County) (State)  |  |   |  |
| <b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: <b>Noturol causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .   |  |   |  |   |  |  |  |   |  |
| <b>ACTUAL SIGNATURE</b> <u>Frank J. Broschant</u> M.D.  |  |   |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>  |  |  |  |   |  |
| <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschant</u>   |  |   |  | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>  |  |  |  |   |  |
| <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>Jan 8 1960</u>  |  |   |  | <b>DATE SIGNED</b>  |  |  |  |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>   |  | <b>22b. DATE THEREOF</b><br><u>1/12/60</u>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Lough's</u>   |  | <b>22d. LOCATION (City, town, or county)</b> (State)<br><u>Cockeysville Balto. Co. Md.</u> |  |   |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS<br><u>Ann L. Khatunian - 1701 M. Cullohs</u>  |  |   |  | <b>24a. REC'D BY REGISTRAR</b> DATE <u>JAN 11 '60</u>   |  | <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Fiana</u>                                |  |   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form No. 10

|                                |  |  |  |
|--------------------------------|--|--|--|
| NAME OF DECEASED<br>_____      |  | SEX<br><input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |  |
| AGE<br>_____                   |  | DATE OF BIRTH<br>_____   |  |
| PLACE OF BIRTH<br>_____        |  | PLACE OF DEATH<br>_____  |  |
| OCCUPATION<br>_____            |  | CAUSE OF DEATH<br>_____  |  |
| MANNER OF DEATH<br>_____       |  | MEDICAL HISTORY<br>_____   |  |
| PRESENT ILLNESS<br>_____       |  | TREATMENT<br>_____   |  |
| PHYSICIAN'S SIGNATURE<br>_____ |  | MEDICAL EXAMINER'S SIGNATURE<br>_____                                |  |
| DATE<br>_____                  |  | TIME<br>_____  |  |
| PLACE<br>_____                 |  | COUNTY<br>_____  |  |
| CITY<br>_____                  |  | STATE<br>_____   |  |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00895

## 0863 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>LANHAM</b> 16-36-2  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>KENSINGTON GARDENS SAN.</b>  |                                  | d. STREET ADDRESS<br><b>9202-3<sup>rd</sup> ST.</b>  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>SAMUEL LEVINE</b>   |                                  | 4. DATE OF DEATH Month Day Year<br><b>JANUARY 18 1960</b>  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>DEC. 12, 1886</b> |
| 9. AGE (In years last birthday) <b>72</b> yrs.  |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BUTCHER-RETIRED</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>MEAT</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>LITHUANIA</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>unknown</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>JULES LEVINE</b>  |                                  | Address<br><b>9202-3<sup>rd</sup> ST. LANHAM, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br><b>260X</b> DUE TO <b>Diabetes Mellitus (Syring)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis (Hypertension)</b><br>(c) <b>Arteriosclerosis (Hypertension)</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>yr</b><br><b>yr</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Dec 15</b> , 19 <b>59</b> , to <b>Jan 18</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 18</b> , 19 <b>60</b> , and that death occurred at <b>3:02 PM</b> , from the causes and on the date stated above.   |                                  |  |  |
| ACTUAL SIGNATURE <b>Sam Allen MD</b>  |                                  | ADDRESS (Street, city or town, state) <b>Kensington, Maryland</b>  |  |
| DATE SIGNED <b>1/18/60</b>  |                                  |  |  |
| PHYSICIAN'S NAME (Type)   |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>JAN. 20, 1960</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>MONTIFIORE CEM.</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>PHILADELPHIA Pa.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Bernard Druebach &amp; Sons</b>  |                                  | ADDRESS<br><b>3501-14 St. NW Washington DC</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>DATE JAN 20 '60</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles S. Kline</b>  |  |

CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| <p>1. NAME OF DECEASED<br/>                 [Faint text, possibly "JOHN DOE"]</p>               |  | <p>2. SEX<br/>                 [Faint text, possibly "Male"]</p>                            |  |
| <p>3. AGE<br/>                 [Faint text, possibly "45 years"]</p>                            |  | <p>4. DATE OF BIRTH<br/>                 [Faint text, possibly "1910-01-01"]</p>            |  |
| <p>5. PLACE OF BIRTH<br/>                 [Faint text, possibly "Baltimore, Md"]</p>            |  | <p>6. OCCUPATION<br/>                 [Faint text, possibly "Teacher"]</p>                  |  |
| <p>7. MARITAL STATUS<br/>                 [Faint text, possibly "Married"]</p>                  |  | <p>8. DATE OF MARRIAGE<br/>                 [Faint text, possibly "1935-06-15"]</p>         |  |
| <p>9. NAME OF WIFE<br/>                 [Faint text, possibly "Jane Doe"]</p>                   |  | <p>10. NAME OF HUSBAND<br/>                 [Faint text, possibly "John Doe"]</p>           |  |
| <p>11. PLACE OF DEATH<br/>                 [Faint text, possibly "Home"]</p>                    |  | <p>12. DATE OF DEATH<br/>                 [Faint text, possibly "1940-03-10"]</p>           |  |
| <p>13. TIME OF DEATH<br/>                 [Faint text, possibly "10:00 AM"]</p>                 |  | <p>14. CAUSE OF DEATH<br/>                 [Faint text, possibly "Heart Disease"]</p>       |  |
| <p>15. MEDICAL HISTORY<br/>                 [Faint text, possibly "Hypertension"]</p>           |  | <p>16. PRESENT ILLNESS<br/>                 [Faint text, possibly "Chest pain"]</p>         |  |
| <p>17. NAME OF PHYSICIAN<br/>                 [Faint text, possibly "Dr. Smith"]</p>            |  | <p>18. NAME OF NURSE<br/>                 [Faint text, possibly "Mrs. Jones"]</p>           |  |
| <p>19. NAME OF BURIAL PLACE<br/>                 [Faint text, possibly "Catholic Cemetery"]</p> |  | <p>20. NAME OF MINISTER<br/>                 [Faint text, possibly "Rev. Brown"]</p>        |  |
| <p>21. NAME OF FUNERAL HOME<br/>                 [Faint text, possibly "Doe Funeral Home"]</p>  |  | <p>22. NAME OF CEMETERY<br/>                 [Faint text, possibly "Catholic Cemetery"]</p> |  |

This certificate is valid only if filed in the office of the Registrar of the State Department of Health, Baltimore, Md.

TO BE FILLED BY THE REGISTRAR OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD.

AS WITNESSED BY THE REGISTRAR OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD.

0813

## CERTIFICATE OF DEATH

Reg. Dist. No.

00896

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>   |  |
| c. LENGTH OF STAY IN 1b <u>APPROX. 5 YEARS</u>   |  | d. STREET ADDRESS <u>8714 LEONARD DR.</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8714 LEONARD DRIVE</u> |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |

|  |                               |  |                                      |
|--|-------------------------------|--|--------------------------------------|
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>CURTIS LEWIS LEVIS</u> |                               | 4. DATE OF DEATH Month Day Year<br><u>Jan. 1 1960</u>  |                                      |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 9, 1879</u> |
| 9. AGE (In years lost birthday) yrs. <u>80</u>                                     |                               | IF UNDER 1 YEAR Months Days Hours Min.   |                                      |

|  |  |  |  |
|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. CREDIT MANAGER</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u> | 11. BIRTHPLACE (State or foreign country) <u>DIST. OF COLUMBIA</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
|--|--|--|--|

|  |  |
|--|--|
| 13. FATHER'S NAME <u>Phillip LEVIS</u> | 14. MOTHER'S MAIDEN NAME <u>CLARA CHAMBERLAINE</u> |
|--|--|

|  |  |  |
|--|--|--|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>578-05-1284</u> | INFORMANT <u>CURTIS W. LEVIS</u> Address <u>8714 LEONARD DRIVE</u> |
|--|--|--|

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-vascular Renal Disease</u><br><u>442X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH <u>1956</u> |
|---|--|--|

|   |  |  |
|---|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|---|--|--|

|  |  |  |                                      |
|--|--|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

|   |  |
|---|--|
| 21. I certify that I attended the deceased from <u>1957</u> to <u>Dec. 31, 1959</u> , that I last saw the deceased alive on <u>Dec. 31, 1959</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above. |  |
|---|--|

|   |                                       |                           |
|---|---------------------------------------|---------------------------|
| ACTUAL SIGNATURE <u>Armand B. Gordon</u> M.D. <u>2828 Conn. Ave. N.W., Wash. DC</u> | ADDRESS (Street, city or town, state) | DATE SIGNED <u>1/1/60</u> |
| PHYSICIAN'S NAME (Type) <u>Armand B. Gordon, M.D.</u>                               |                                       |                           |

|  |                                      |  |   |
|--|--------------------------------------|--|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>                                    | 22b. DATE THEREOF <u>Jan 4, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u> | 22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don DeVol</u> ADDRESS <u>2224 Wia. Ave. NW-W.C.</u> |                                      | 24a. REC'D BY REGISTRAR <u>JAN 11 '60</u>                      | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>                             |

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1



## 0939 CERTIFICATE OF DEATH

Reg. Dist. No. 215

|   |                                  |   |                                    |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>Fredericksburg</b>           |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>25</b>  |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>U.S. NAVAL HOSPITAL, NNMC, BETHESDA, MD.</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Madeline</b> Middle <b>Mary</b> Last <b>LONG</b>  |                                  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>1</b> Year <b>1960</b>  |                                    |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-22-15</b> |
| 9. AGE (In years last birthday)<br><b>44</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>44</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                    |
| 13. FATHER'S NAME<br><b>LeRoy BOWLER</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Lillian PITTS</b>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |                                    |
| INFORMANT<br>(Husband) <b>Paul LONG</b>   |                                  | Address<br><b>Same as #2</b>  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subacute Bacterial Endocarditis</b><br>DUE TO (b) <b>Tetralogy of Fallot (Congenital H.D.)</b><br>DUE TO (c) <b>7540</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                                  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that I attended the deceased from <b>7 December</b> , 19 <b>59</b> , to <b>1 January</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1 January</b> , 19 <b>60</b> , and that death occurred at <b>2:30AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>1-1-60</b> |                                  |   |                                    |
| ACTUAL SIGNATURE <b>Joseph E. Sticker</b>   |                                  | M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>  |                                    |
| PHYSICIAN'S NAME (Type) <b>STITCHER, J.E.</b>   |                                  | LT MC USN   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>1-5-60</b>  |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NATIONAL</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b>   |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wheeler &amp; Thompson</b>   |                                  | 24a. REC'D. BY REGISTRAR<br><b>JAN 5 60</b>   |                                    |
| ADDRESS<br><b>705 Princess Anne St. Fredericksburg, Virginia</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Evans</b>  |                                    |

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

U.S. DEPARTMENT OF HEALTH  
CENTRAL BUREAU OF DEATH



U.S. DEPARTMENT OF HEALTH  
CENTRAL BUREAU OF DEATH  
WASHINGTON, D.C.

U.S. DEPARTMENT OF HEALTH  
CENTRAL BUREAU OF DEATH  
WASHINGTON, D.C.

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CENTRAL BUREAU OF DEATH  
WASHINGTON, D.C.

U.S. DEPARTMENT OF HEALTH  
CENTRAL BUREAU OF DEATH  
WASHINGTON, D.C.



CERTIFICATE OF DEATH



Blank form with horizontal lines for text entry.



## CERTIFICATE OF DEATH

Reg. Dist. No.

00899

|   |                                  |  |                                     |
|---|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b> |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>10220 River Road</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>PEYTON</b> Middle <b>M.</b> Last <b>MANNAR</b>  |                                  | 4. DATE OF DEATH<br>Jan. 4, 1960   |                                     |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>2/26/'03</b> |
| 9. AGE (In years last birthday)<br><b>56</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  | 11. IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Crushed Stone</b>  |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |                                     |
| 13. FATHER'S NAME<br><b>Claiborne H. Mannar</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Martha Magruder</b>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>216-18-0668</b>  |                                     |
| 17. INFORMANT<br><b>Mrs Hazel A. Mannar-Item# 2</b>   |                                  | Address  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0 Acute Congestive Heart Failure</b><br>DUE TO (b) <b>Cardiomyopathic Heart Disease</b><br>DUE TO (c) <b>Coronary Arteriosclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b><br><b>7 yrs.</b><br><b>7 yrs.</b>                   |                                  |  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that I attended the deceased from <b>Sept 12/22</b> , 19 <b>59</b> to <b>Jan 4</b> , 19 <b>60</b> that I last saw the deceased alive on <b>12/22</b> , 19 <b>59</b> , and that death occurred at <b>2:20</b> AM, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>1835 Eye St., N.W., Wash., D.C.</b><br>DATE SIGNED <b>1/4/59</b> |                                  |  |                                     |
| ACTUAL SIGNATURE <b>Alvin I. Kay</b> M.D.   |                                  | PHYSICIAN'S NAME (Type) <b>Alvin I. Kay</b> 1835 Eye St., N.W., Wash., D.C.  |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>1/6/60</b>   |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rockville</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Rockville, Maryland</b>  |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Tyson Wheeler Funeral Home</b><br><b>1331 E. Montgomery Ave., Rockville, Md</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>JAN 7 '60</b><br>DATE  |                                     |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |                                  |  |                                     |

1

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

0837

1900-1901

1900-1901

1900-1901

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0855 Item 7 Film 255-2-60 et

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

00900

|   |                               |   |  |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>  |                               | c. LENGTH OF STAY IN lb <b>8 months</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens</b>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>BRIDGET PETER MARTIN</b>   |                               | 4. DATE OF DEATH Month Day Year <b>January 26 19 60</b>   |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Nov 15, 1877</b>                     |
| 9. AGE (In years lost birthday) <b>82 yrs.</b>  |                               | 10. IF UNDER 1 YEAR Months <b>2</b> Days <b>11</b>  | 11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>   | 11. BIRTHPLACE (State or foreign country) <b>Ireland</b> |
| 12. CITIZEN OF WHAT COUNTRY? <b>US</b>  |                               | 13. FATHER'S NAME <b>Unknown</b>  |  |
| 14. MOTHER'S MAIDEN NAME <b>Unknown</b>   |                               | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  |
| 16. SOCIAL SECURITY NO. <b>190-28-5811-A</b>  |                               | 17. INFORMANT Address <b>Daughter Mrs. Martina MacDonald-same as 2d</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO (b) <b>493X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b></b><br>DUE TO (b) <b></b><br>DUE TO (c) <b></b><br>INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> |                               |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis; cerebral arteriosclerosis</b>  |                               |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                               |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>   |                               |   |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                               |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               |   |  |
| 20f. (City or town) (County) (State)  |                               |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 19 59</b> to <b>26 JAN 19 60</b> , that (I) (we) lost saw the deceased alive on <b>26 JAN 19 60</b> , and that death occurred at <b>1:30 P</b> M, from the causes and on the date stated above.   |                               |   |  |
| 22a. SIGNATURE <b>Robert T. Kelley</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |                               |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Robert T. Kelley</b> M.D. 22d. ADDRESS <b>3132 - 16th St. N. W. Wash. D. C. 1/26/60</b>   |                               |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 23b. DATE THEREOF <b>1/28/60</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>   |                               | 23d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>  |                               | 25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>   |  |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>   |                               | DATE <b>JAN 28 '60</b>  |  |



RECEIVED  
JAN 12 1977  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-157344)  
SUBJECT: [Illegible]

[The following section contains several paragraphs of text that are extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing an investigation.]

Robert T. Kelley  
M.B. 3132 - 15th St. N.W. Wash. D.C. 20037

Robert A. Humphrey  
1125 60  
Sacramento, California

### MEDICAL CERTIFICATION

VS. A15ME(5)  
5M 9/55





# CERTIFICATE OF DEATH

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0942

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>New York</b> b. COUNTY  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>5 days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Newton</b> Last <b>McAllister</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>8</b> Year <b>19 60</b>  |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>              |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>March 6, 1918</b>   |  |
| 9. AGE (In years last birthday)<br><b>41</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  | 11. IF UNDER 24 HRS.<br>Months Days Hours Min.   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Carpentry</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>                                     |  |
| 13. FATHER'S NAME<br><b>Earl McAllister</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Grace Hazen</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>WW II 094-03-8465</b>  |  | INFORMANT <b>The Medical Record</b> Address<br><b>The Clinical Center, Bethesda 14, Maryland</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Aortic stenosis and insufficiency</b><br>DUE TO<br>(c) <b>Rheumatic heart disease</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>15 years</b><br><b>15 + years</b> |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                           |  |
| 20f. (City or town) (County) (State)   |  |   |  | 21. I certify that I attended the deceased from <b>January 3, 19 60</b> to <b>January 8, 19 60</b> that I last saw the deceased alive on <b>January 8, 19 60</b> , and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above. |  |  |  |
| ACTUAL SIGNATURE <b>Charles A. Chidsey</b> M.D.  |  |   |  | ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>1/9/60</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Charles A. Chidsey, Jr., M.D.</b>   |  |   |  | National Institutes of Health<br>Bethesda 14, Maryland   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial-transit 1-9-60</b>  |  | 22b. DATE THEREOF<br><b>1-9-60</b>            |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Pine Hill Cem.</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Sparrowbush, New York</b>                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>ROBERT A. PUMPHREY</b>  |  |   |  | ADDRESS<br><b>Bethesda, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 '60</b>  |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |  |  |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

The Clinical Center  
National Institutes of Health  
Bethesda, Md., Maryland

Charles A. Chubb, Jr., M.D.

Spottsylvania, New York

Pine Hill, Md.

ROBERT A. HUMPHREY

Bethesda, Md.

January 2, 60

January 8, 60

Rheumatic heart disease

Acute rheumatism and insulinitis

Cardiac arrest

001-02-3855 The Clinical Center, Bethesda, Md., Maryland

John Halliday

Grace Hagen  
The Medical Record

Carpeting

New York

White

March 8, 1918

John Lennon

Wallpaper

The Clinical Center, Bethesda, Md., Md.

103 West Main Street

5 days

Post-mortem

Hemorrhage

New York

## 0833 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  |
| c. LENGTH OF STAY IN 1b <u>3 yrs</u>   |  | d. STREET ADDRESS <u>7124 Carroll Ave.</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7124 Carroll Ave.</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>JANE</u> Last <u>MCCARTY</u>  |  | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>14</u> Year <u>1960</u>  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>white</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-28-74</u>  |
| 9. AGE (In years last birthday) <u>85</u> yrs.   |  | IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | 10b. KIND OF BUSINESS, OR INDUSTRY <u>At Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Thorn Hill Penna</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>John C. Yund</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Catherine Nichols</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  | 16. SOCIAL SECURITY NO. <u>none</u>  |  |
| 17. INFORMANT <u>Mola McCarty</u> Address <u>7124 Carroll Ave Takoma Park Md</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio vascular failure</u><br>DUE TO <u>- cerebro vascular accident</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>- arterial sclerosis, cerebral and generalized</u><br>(c) <u>generalized</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>14 h. 45 min</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>fly infestation</u>   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>1-14-</u> 19 <u>60</u> , to <u>1-14-</u> 19 <u>60</u> , that I last saw the deceased alive on <u>1-14-</u> 19 <u>60</u> , and that death occurred at <u>11:45 P</u> M, from the causes and on the date stated above.  |  |  |  |
| ACTUAL SIGNATURE <u>Veronica Provost</u> M.D. <u>10236 Natl. Dr. S. East Spring Maryland</u>   |  | ADDRESS (Street, city or town, state) DATE SIGNED  |  |
| PHYSICIAN'S NAME (Type) <u>VERONICA T. R.</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>1/18/60</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>mt Royal</u>   | 22d. LOCATION (City, town or county) (State) <u>Blenshaw Penna</u>                             |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>1400 Chapin St</u>   |  | 24a. REC'D BY REGISTRAR <u>DATE JAN 21 '60</u>   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
0945 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00905

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Argentinian</u> b. COUNTY                           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elmwood</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Buenos Aires</u> 15x-1   |  |
| c. LENGTH OF STAY IN 1b <u>2 days</u>  |  | d. STREET ADDRESS <u>2024 Arenales</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brook Grove Rd.</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Winifred Margaret Annie Bell McNab</u>  |  | 4. DATE OF DEATH Month <u>Jan</u> Day <u>31</u> Year <u>1960</u>   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-12-1903</u> 5-6 yrs.     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Scotland</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Scotland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>United Kingdom</u>   |  |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>NONE</u>  |  |
| 17. INFORMANT <u>British Passport Record</u>   |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Corneal Failure</u><br>431X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sub acute myocarditis</u><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)           |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Brosech</u> M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. BROSECH 2nd</u>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>   |  | 22b. DATE THEREOF <u>2/1/1960</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Pawlars Sons, Wash. D.C.</u>  |  | 24a. REC'D BY REGISTRAR <u>FEB 3 '60</u>   |  |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>  |  |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

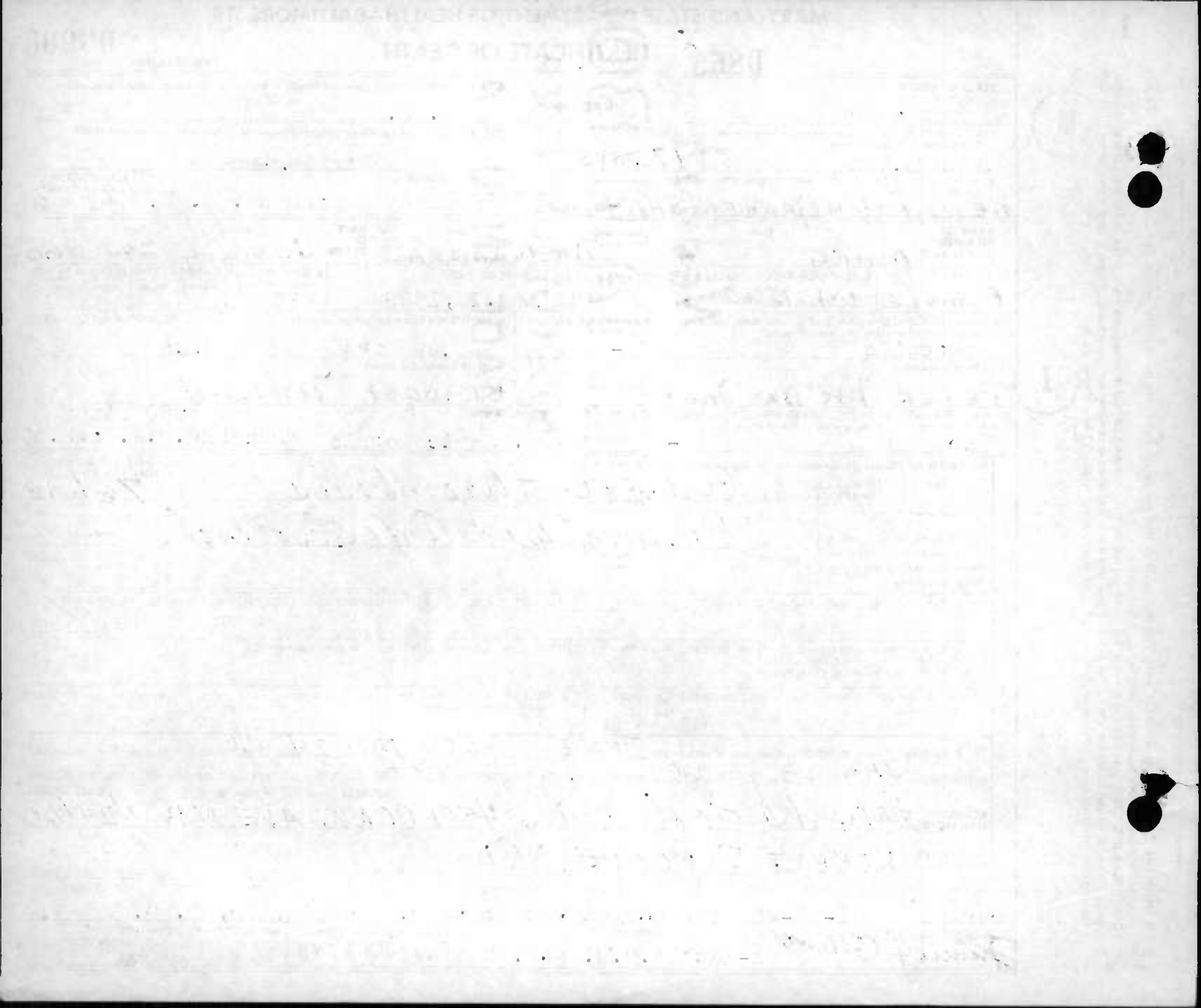
00906

0865

|   |  |  |   |          |  |
|---|--|--|---|----------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>D. C.</u> b. COUNTY <u>✓</u> |          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>                          |          |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDEN SANITARIUM</u>  |  |  | d. STREET ADDRESS <u>5950 Piney Branch Rd. N. W.</u>  |          |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |          |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY A. McNAMARA</u>   |  |  | 4. DATE OF DEATH Month Day Year <u>JANUARY 24 1960</u>  |          |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 12, 1869</u>   |          | 9. AGE (In years last birthday) <u>90</u> yrs.     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>   | 11. BIRTHPLACE (State or foreign country) <u>New York</u>   |          | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>            |
| 13. FATHER'S NAME <u>PETER McDarriott</u>   |  |  | 14. MOTHER'S MAIDEN NAME <u>Bridget Moran</u>   |          |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)   |  |  | 16. SOCIAL SECURITY NO. <u>-</u> INFORMANT Address <u>5950 Piney Branch Rd. N.W. Wash. DC</u>                                     |          |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>332X Cerebral thrombosis</u><br>DUE TO (b) <u>Generalized Arteriosclerosis</u><br>DUE TO (c) <u>-</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |          | INTERVAL BETWEEN ONSET AND DEATH <u>76 hrs.</u>    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |   |          |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |          |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)   | (County) | (State)  |
| 21. I certify that I attended the deceased from <u>JUNE 1960</u> to <u>JAN. 24, 1960</u> , that I last saw the deceased alive on <u>JAN 23, 1960</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.  |  |  |   |          |  |
| ACTUAL SIGNATURE <u>Robert S. Poole M.D.</u>  |  |  | ADDRESS (Street, city or town, state) <u>4501 CONN AVE, N.W.</u> DATE SIGNED <u>1/24/60</u>                                       |          |  |
| PHYSICIAN'S NAME (Type) <u>ROBERT S. POOLE, M.D.</u>  |  |  |   |          |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>1-27-60</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>  | 22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>  |          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>3821-14th St. N.W. Wash. DC</u>   |  |  | 24a. REC'D BY REGISTRAR DATE <u>JAN 27 '60</u>  |          | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







0834

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                               |  |                                 |   |                 |   |  |
|---|-------------------------------|--|---------------------------------|---|-----------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>  |                               |  |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>47X-3</u> ✓<br>b. COUNTY <u>WASHINGTON</u> |                 |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |                               |  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia, WASHINGTON</u>                        |                 |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>  |                               |  |                                 | d. STREET ADDRESS <u>1440 Tuckerman St. N.W.</u>  |                 |   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                 |   |                 |   |  |
| 3. NAME OF DECEASED (Type or print)   |                               | First <u>Samuel</u> Middle <u>Israel</u> Last <u>Mincosky</u>  |                                 | 4. DATE OF DEATH  |                 | Month <u>Jan.</u> Day <u>30</u> Year <u>1960</u>                  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-15-87</u> | 9. AGE (In years last birthday) <u>72</u> yrs.  | IF UNDER 1 YEAR | IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry</u>   |                                 | 11. BIRTHPLACE (State or foreign country) <u>Poland</u>   |                 | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>                          |  |
| 13. FATHER'S NAME <u>Phillip Mincosky</u>   |                               |  |                                 | 14. MOTHER'S MAIDEN NAME <u>Sarah Goldman</u>   |                 |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |                               | 16. SOCIAL SECURITY NO. <u>577-07-6871</u>   |                                 | INFORMANT <u>Hosp. Records</u>  |                 | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <u>MYOCARDIAL INFARCTION ACUTE</u><br>DUE TO<br>(c) <u>ARTERIOSCLEROTIC AND HYPERTENSIVE HEART DISEASE</u> |                               |  |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 DAYS</u><br><u>3 DAYS</u><br><u>10 YEARS</u>   |                 |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>  |                               |  |                                 |   |                 |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                 |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                 | 20f. (City or town) (County) (State)                              |  |
| 21. I certify that I attended the deceased from <u>8/10</u> , 19 <u>59</u> , to <u>1/30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/30</u> , 19 <u>60</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.  |                               |  |                                 |   |                 |   |  |
| ACTUAL SIGNATURE <u>David Goldenberg</u>  |                               |  |                                 | ADDRESS (Street, city or town, state) <u>6727 16th St. N.W. WASHINGTON, D.C.</u>  |                 |   |  |
| PHYSICIAN'S NAME (Type) <u>DAVID GOLDENBERG</u>   |                               |  |                                 | DATE SIGNED <u>1/30/60</u>  |                 |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                               | 22b. DATE THEREOF <u>2-1-60</u>  |                                 | 22c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL CEM</u>   |                 | 22d. LOCATION (City, town, or county) (State) <u>OXON HILL MD</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Margulsky &amp; Sons - 3501-14th St N.W.</u>   |                               |  |                                 | 24a. REC'D BY REGISTRAR <u>FEB 3 '60</u>  |                 | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>                 |  |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained at the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

083-1 CERTIFICATE OF DEATH

State of Maryland  
County of Prince George's  
I, the undersigned, being a duly qualified medical officer of health for the County of Prince George's, do hereby certify that  
[Name of Deceased] was born [Date of Birth] at [Place of Birth]  
and that he/she died on [Date of Death] at [Place of Death]  
at the age of [Age] years, [Sex], [Race]  
the cause of death being [Cause of Death]  
as shown by the medical history and the post-mortem examination.  
Witness my hand and the seal of the County of Prince George's at [Place] this [Date] day of [Month], 19[Year].



Signature of Medical Officer of Health  
[Signature]  
[Name]  
Medical Officer of Health  
County of Prince George's  
Maryland



0856

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Gaithersburg</b>   |   | c. LENGTH OF STAY IN 1b<br><b>11 yrs. 3 mo.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Asbury Methodist Home</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ida</b> Middle <b>Watson</b> Last <b>Mitchell</b>   |   | 4. DATE OF DEATH<br>Month <b>JAN</b> Day <b>24</b> Year <b>1960</b>   |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 9, 1867</b>   |
| 9. AGE (In years last birthday)<br><b>93</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Isaac C. Carroll</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Watson</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>—</b>  |   | 16. SOCIAL SECURITY NO.<br><b>—</b>   |   |
| INFORMANT<br><b>Asbury Methodist Home Records As B</b>  |   | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>pneumonia</b><br>433.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>congestive heart failure</b><br>DUE TO<br>(c) <b>auricular fibrillation</b> |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>5-23</b> , 19 <b>56</b> , to <b>1-24</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-20</b> , 19 <b>60</b> , and that death occurred at <b>11:05</b> M, from the causes and on the date stated above.  |   |   |   |
| ACTUAL SIGNATURE <b>Sarah E. Glover</b>   |   | ADDRESS (Street, city or town, state) <b>10128 CEDAR LANE KENSINGTON, Md.</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Sarah E. Glover, M.D.</b>  |   | DATE SIGNED <b>1-24-60</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>1-27-60</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Wesleyan Chapel</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>HARFORD CO. Havre De Grace, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R. Madison Mitchell</b>  |   | 24a. REC'D BY REGISTRAR<br><b>JAN 27 '60</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Carlton S. Kline</b>   |   |   |   |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The low requires that the death certificate be executed within 24 hours of death.

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

• • • • •

## CERTIFICATE OF DEATH

Reg. Dist. No.

00910

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b> ✓                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fairfax 2,</b> <b>83x-3</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |                                  | d. STREET ADDRESS<br><b>7 Barlow Road</b>   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Audley</b> Middle <b>Elaine</b> Last <b>Moore</b>  |                                  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>18</b> Year <b>1960</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 7, 1923</b> |
| 9. AGE (In years last birthday)<br><b>36</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <b>36</b> Days <b>36</b> Hours <b>36</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Editor</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Journalism</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>William V. Thomas</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Helen Perry</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Unascertainable</b>   |  |
| INFORMANT <b>The Medical Record</b> Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>   |                                  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic failure and Pulmonary atelectasis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Staphylococcal septicemia and Jejunal fistula</b><br>DUE TO<br>(c) <b>Choriocarcinoma with multiple metastases</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b><br><b>weeks</b><br><b>months</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>December 6, 1959</b> to <b>January 18, 1960</b> , that I last saw the deceased alive on <b>January 18, 1960</b> , and that death occurred at <b>7:40 PM</b> , from the causes and on the date stated above.   |                                  |   |  |
| ACTUAL SIGNATURE <b>Saul Geruth</b>  |                                  | ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b><br><b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>                 |  |
| PHYSICIAN'S NAME (Type)<br><b>Saul Geruth, M.D.</b>  |                                  | DATE SIGNED<br><b>1/19/60</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal-Burial</b>   |                                  | 22b. DATE THEREOF<br><b>1/21/60</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>National Memorial Park</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Falls Church, Va.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>V. S. Emery</b>   |                                  | ADDRESS<br><b>Alexandria, Va.</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>JAN 21 '60</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>  |  |

CERTIFICATE OF DEATH

001

Residence

Virginia

Occupation

Monetary

Bellevue

13 days

January 2,

The Hospital Center, Bethesda, Md., 100, 7 Bayview Road

100, 7 Bayview Road

100, 7 Bayview Road

Moore

Marine

Anders

30

April 7, 1963

White

Female

West Virginia

Journalist

Married

William V. Thomas

Helen Perry

Unsubstantiated The Clinical Center, Bethesda, Md., Maryland

no

10 days

Hepatic failure and pulmonary metastasis

weeks

Staphylococcal septicemia and tetanal fistula

months

Chondrosarcoma with multiple metastases

January 15, 1960

60

January 16

1/19/60

The Clinical Center  
National Institutes of Health  
Bethesda, Md., Maryland

Sanit Center, N.C.

Received with N 100  
Examination, etc.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00911

Reg. Dist. No.

0835

FOR STATE  
HEALTH DEPT.

|  |   |  |  |   |   |
|--|---|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Monty</u> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>   |   | c. LENGTH OF STAY IN lb<br><u>2 days</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>56 Silver Spring</u> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Wash. San. + Hospital</u>   |   |  | d. STREET ADDRESS<br><u>10409 Georgia Ave</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br><u>Jaqueline Ann Moorefield</u>   |   |  | 4. DATE OF DEATH<br>Month <u>Jan</u> Day <u>21</u> Year <u>1960</u>  |   |   |
| 5. SEX<br><u>female</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>               | 8. DATE OF BIRTH<br><u>7-24-38</u>   |   | 9. AGE (in years last birthday)<br><u>21 yrs.</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>none</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><u>D.C.</u>  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.C.</u>   |
| 13. FATHER'S NAME<br><u>Roy Moorefield</u>   |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Anna M. Hall</u>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>NO</u>   |   | 16. SOCIAL SECURITY NO.<br><u>NONE</u>   |  | 17. INFORMANT<br><u>Hosp Record</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Phen barital poisoning</u><br><u>2940</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>epileptic seizure</u><br>DUE TO (c)  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br><u>Reported also to have been mentally disturbed</u>  |   |  |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Taken a large number of Phen. bar - following epileptic seizure</u> |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>noon</u> <u>1-19</u> 19 <u>60</u><br>p. m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input checked="" type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>home</u>  |  | 20f. (City or town)<br><u>Silver Spring Monty md</u>  | (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |  |   |   |
| ACTUAL SIGNATURE<br><u>Frank J. Broschart</u>  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | DATE SIGNED   |   |
| EXAMINER'S NAME (Type)<br><u>FRANK J. Broschart</u>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |   | 22b. DATE THEREOF<br><u>1/25/60</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>GATE OF HEAVEN CEMETERY</u>  |   |
| 22d. LOCATION (City, town, or county)<br><u>MONTGOMERY COUNTY, MARYLAND</u>  |   | 22e. LOCATION (State)<br><u>MARYLAND</u>   |  | 22f. LOCATION (City, town, or county)<br><u>SILVER SPRING, MD.</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Raymond G. Jiska</u>  |   | 23a. ADDRESS<br><u>SILVER SPRING, MD.</u>  |  | 24a. REC'D BY REGISTRAR<br><u>JAN 25 '60</u>  |   |
| 23b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>   |   | 23c. ADDRESS   |  | 23d. REGISTRAR'S SIGNATURE  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first of these is the fact that the system is not a simple one, but a complex one, involving many different factors, and the results of the system are not always predictable. 2. The second is the fact that the system is not a simple one, but a complex one, involving many different factors, and the results of the system are not always predictable. 3. The third is the fact that the system is not a simple one, but a complex one, involving many different factors, and the results of the system are not always predictable. 4. The fourth is the fact that the system is not a simple one, but a complex one, involving many different factors, and the results of the system are not always predictable. 5. The fifth is the fact that the system is not a simple one, but a complex one, involving many different factors, and the results of the system are not always predictable. 6. The sixth is the fact that the system is not a simple one, but a complex one, involving many different factors, and the results of the system are not always predictable. 7. The seventh is the fact that the system is not a simple one, but a complex one, involving many different factors, and the results of the system are not always predictable. 8. The eighth is the fact that the system is not a simple one, but a complex one, involving many different factors, and the results of the system are not always predictable. 9. The ninth is the fact that the system is not a simple one, but a complex one, involving many different factors, and the results of the system are not always predictable. 10. The tenth is the fact that the system is not a simple one, but a complex one, involving many different factors, and the results of the system are not always predictable.



## 0945 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Virginia</b><br>b. COUNTY <b>Arlington</b>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>  |  |  |  | c. LENGTH OF STAY IN 1b <b>124 days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>   |  |  |  | e. STREET ADDRESS <b>2343 North Vernon Street</b>   |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Anne</b> Middle <b>Geraldine</b> Last <b>Mosher</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>19</b> Year <b>1960</b>   |  |  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>April 23, 1913</b>                                   |  |
| 9. AGE (In years lost birthday) <b>46</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min.  |  | IF UNDER 24 HRS.<br>Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>                             |  |
| 13. FATHER'S NAME <b>Walter Ballard</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Sadie Bracey</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  | 16. SOCIAL SECURITY NO. <b>None</b>  |  | INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral edema</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pyonephrosis of Left kidney</b><br>DUE TO <b>Carcinoma of the breast with metastasis to bones</b><br>(c) <b>skin, lungs, liver, abdominal cavity &amp; adrenal glands</b> |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>170x</b>   |  |  |  |   |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>   |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b><br>p. m.   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that I attended the deceased from <b>September 17, 1959</b> to <b>January 19, 1960</b> , that I last saw the deceased alive on <b>January 19, 1960</b> , and that death occurred at <b>9:00 AM</b> , from the causes and on the date stated above.  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>John L. Lewis, Jr.</b>  |  |  |  | ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>1-19-60</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>John L. Lewis, Jr., M.D.</b>   |  |  |  | National Institutes of Health<br><b>Bethesda 14, Maryland</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>   |  | 22b. DATE THEREOF <b>Jan. 22, 1960</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>C. D. Lee M.D.</b> ADDRESS <b>Ives Funeral Home, Inc. Arlington, Va.</b>  |  |  |  | 24a. REC'D BY REGISTRAR <b>JAN 21 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>                        |  |

1

Page 4

TO HO... ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

004

Washington

Virginia

Washington

Washington

123 days

Washington

231 North Vernon Avenue

The National Center, Bethesda 1, Md.

Washington

October

Anna

January 12, 1930

10

April 23, 1913

White

Female

South Carolina

Marriage

Married

Edith Gracey

Voluntarily

The National Center, Bethesda 1, Maryland

None

10

None

Corporal

None

Photographs of 1-12-13

Examination of the body with reference to the  
cause of death, and the following findings were made:

January 12, 1930

9:00 A.M.

January 12, 1930

1-12-30

The Clinical Center

National Institute of Health

Bethesda 1, Maryland

Room 1, Suite 11, Bldg.

Washington, Virginia

Washington, Virginia

Room 1, Suite 11, Bldg.

Washington, Virginia

Room 1, Suite 11, Bldg.

0946

## CERTIFICATE OF DEATH

00913

Reg. Dist. No.

|   |                                  |   |  |   |   |  |  |
|---|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Kemptown</b>  |                                  |   |  | c. LENGTH OF STAY IN 1b<br><b>Years</b>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>RFD # 1, Monrovia</b>   |                                  |   |  | e. STREET ADDRESS<br><b>RFD #1, Monrovia</b>  |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>William T.</b> Middle <b>Moxley</b> Last <b></b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>23</b> Year <b>1960</b>   |   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 29, 1888</b> | 9. AGE (In years last birthday)<br><b>71</b> yrs.   | IF UNDER 1 YEAR<br>Months <b></b> Days <b></b> Hours <b></b> Min. <b></b> |  | IF UNDER 24 HRS.<br>Months <b></b> Days <b></b> Hours <b></b> Min. <b></b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Kempton, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Ezekiel Moxley</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Hattie V. Thompson</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>578-09-2537</b>   |  | 17. INFORMANT<br>Address<br><b>Howard C. Moxley, Monrovia, Md.</b>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (c) <b></b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Several days</b><br><b>Several months</b> |                                  |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b></b>   |                                  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                 |  |
|   |                                  |   |  | 20f. (City or town)<br><b></b>  |   | (County) <b></b> (State) <b></b>   |  |
| 21. I certify that I attended the deceased from <b>Jan., 1960</b> , to <b>Jan., 1960</b> , that I last saw the deceased alive on <b>Jan 23, 1960</b> , and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>900 So Main St</b> DATE SIGNED <b>1/25/60</b>  |                                  |   |  |   |   |  |  |
| ACTUAL SIGNATURE <b>W.B. Culwell</b> M.D.   |                                  |   |  | PHYSICIAN'S NAME (Type) <b>W.B. Culwell</b>   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  |   |  | 22b. DATE THEREOF<br><b>Jan. 26, 1960</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Montgomery Meth.</b>                          |  |
| 22d. LOCATION (City, town, or county)<br><b>Clagettsville, Md.</b>  |                                  |   |  | 22e. LOCATION (City, town, or county)<br><b></b>  |   | (State) <b></b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Oliver L. Mylesworth</b>   |                                  |   |  | ADDRESS<br><b>Damascus, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 27 '60</b>                                      |  |
|   |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur P. Kenna</b>  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                                      |  |                                    |  |
|--------------------------------------|--|------------------------------------|--|
| NAME OF DECEASED<br>[REDACTED]       |  | SEX<br>[REDACTED]                  |  |
| DATE OF BIRTH<br>[REDACTED]          |  | PLACE OF BIRTH<br>[REDACTED]       |  |
| DATE OF DEATH<br>[REDACTED]          |  | PLACE OF DEATH<br>[REDACTED]       |  |
| TIME OF DEATH<br>[REDACTED]          |  | CAUSE OF DEATH<br>[REDACTED]       |  |
| MANNER OF DEATH<br>[REDACTED]        |  | MEDICAL HISTORY<br>[REDACTED]      |  |
| OCCUPATION<br>[REDACTED]             |  | EDUCATION<br>[REDACTED]            |  |
| RELIGION<br>[REDACTED]               |  | MARITAL STATUS<br>[REDACTED]       |  |
| SIGNATURE OF DECEASED<br>[REDACTED]  |  | SIGNATURE OF WITNESS<br>[REDACTED] |  |
| SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | SIGNATURE OF CORONER<br>[REDACTED] |  |
| SIGNATURE OF JURY<br>[REDACTED]      |  | SIGNATURE OF JUDGE<br>[REDACTED]   |  |

RECEIVED  
 BALTIMORE  
 DEPARTMENT OF HEALTH  
 JAN 10 1918







0814

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                               |  |                                 |
|--|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b><br>c. LENGTH OF STAY IN 1b <b>20 yrs.</b>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b> |                                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10,007 Rogart Road</b>   |                               | d. STREET ADDRESS <b>10,007 Rogart Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EDWARD</b> Middle <b>C.</b> Last <b>MULLER</b>   |                               | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>20</b> Year <b>19 60</b>  |                                 |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>5/29/89</b> |
| 9. AGE (In years last birthday) <b>70</b>  |                               | IF UNDER 1 YEAR: Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min. <b>70</b>  |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber, steam fitter</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Woodward &amp; Lothrop</b>  |                                 |
| 11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                 |
| 13. FATHER'S NAME <b>WILLIAM MULLER</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>ELIZABETH A. PORTS</b>   |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                               | 16. SOCIAL SECURITY NO. <b>577-01-6285</b>   |                                 |
| 17. INFORMANT <b>Mrs. Mary M. Muller, 10,007 Rogart Road Silver Spring, Md.</b>  |                               | Address  |                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b><br><b>434.4</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |  |                                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  |                                 |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                               |  |                                 |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b> p. m.   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                 |
| 21. I certify that I attended the deceased from <b>19 47</b> to <b>20 Jan, 1960</b> , that I last saw the deceased alive on <b>18 Jan, 1960</b> , and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>9006 Glenville Rd, Silver Spring, Md</b><br>DATE SIGNED <b>1/20/60</b>   |                               |  |                                 |
| ACTUAL SIGNATURE <b>William D. Aud</b> M.D.  |                               | DATE SIGNED <b>1/20/60</b>   |                                 |
| PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>  |                               | ADDRESS <b>Silver Spring, Md</b>   |                                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                               | 22b. DATE THEREOF <b>1/23/60</b>   |                                 |
| 22c. NAME OF CEMETERY OR CREMATORY <b>GREEN HILL CEMETERY</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>BERRYVILLE, VIRGINIA</b>  |                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b><br><b>Raymond A. Ziska</b>  |                               | 24a. REC'D BY REGISTRAR <b>JAN 25 '60</b>  |                                 |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>   |                               |  |                                 |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARSHALL STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

FILED IN

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| DECEASED<br>NAME<br>JAMES EARL RAY               |  | SEX<br>MALE   |  | DATE OF BIRTH<br>MAY 19 1928                     |  |
| PLACE OF BIRTH<br>MOBILE, ALABAMA                |  | RACE<br>WHITE   |  | HEIGHT<br>5' 11"                                 |  |
| WEIGHT<br>175 LBS.                               |  | BUILD<br>SLIM   |  | EYES<br>BLUE                                     |  |
| HAIR<br>BROWN                                    |  | COMPLEXION<br>FAIR  |  | MARKS<br>NONE                                    |  |
| OCCUPATION<br>MEMBER OF CONGRESS                 |  | PRESENT ADDRESS<br>435 SOUTH GLENN STREET<br>MEMPHIS, TENNESSEE 38102 |  | DATE OF DEATH<br>APRIL 4 1968                    |  |
| CAUSE OF DEATH<br>HEART DISEASE                  |  | MANNER OF DEATH<br>SUICIDE  |  | PLACE OF DEATH<br>MEMPHIS, TENNESSEE             |  |
| TIME OF DEATH<br>9:01 AM                         |  | SIGNATURE OF DECEASED<br>JAMES EARL RAY                               |  | SIGNATURE OF WITNESS<br>JAMES EARL RAY           |  |
| SIGNATURE OF PHYSICIAN<br>JAMES EARL RAY         |  | SIGNATURE OF CORONER<br>JAMES EARL RAY                                |  | SIGNATURE OF JURY<br>JAMES EARL RAY              |  |
| SIGNATURE OF DEATH CERTIFICATE<br>JAMES EARL RAY |  | SIGNATURE OF DEATH CERTIFICATE<br>JAMES EARL RAY                      |  | SIGNATURE OF DEATH CERTIFICATE<br>JAMES EARL RAY |  |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |  |                                    |  |  |  |  |  |  |  |   |  |
|--|--|------------------------------------|--|--|--|--|--|--|--|---|--|
| Item 18 Film 255 2-4-60 ams  |  |                                    |  |  |  |  |  |  |  |   |  |
| 0837 CERTIFICATE OF DEATH  |  |                                    |  |  |  |  |  |  |  |   |  |
| Reg. Dist. No. 00916   |  |                                    |  |  |  |  |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |                                    |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>New Jersey</u> b. COUNTY <u>✓</u>                   |  |  |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  |                                    |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbury</u>   |  |  |  | 67X-3  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>  |  |                                    |  | d. STREET ADDRESS <u>36 Hupton Ave.</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Harry</u> Middle <u>(W.M.W.)</u> Last <u>Nelson</u>  |  |                                    |  | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>7</u> Year <u>1960</u>   |  |  |  |  |  |   |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>1-25-96</u>  |  | 9. AGE (In years last birthday) <u>63</u> yrs.   |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician -</u>   |  |                                    |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>                                  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                  |  |
| 13. FATHER'S NAME <u>Nels Nelson</u>   |  |                                    |  | 14. MOTHER'S MAIDEN NAME <u>Ida Johnson</u>  |  |  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I. - Army</u>  |  |                                    |  | 16. SOCIAL SECURITY NO. <u>Hospital Records</u>  |  |  |  | INFORMANT Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the tail of the pancreas with metastasis</u><br>157X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                    |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>               |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                    |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |  |                                    |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I attended the deceased from <u>Jan 6</u> , 19 <u>60</u> , to <u>Jan 7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>60</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>2201 Carroll Ave</u> DATE SIGNED <u>1-7-60</u><br>ACTUAL SIGNATURE <u>James H. [Signature]</u> M.D. <u>Takoma Park, Maryland</u><br>PHYSICIAN'S NAME (Type) <u>Takoma Park, Maryland</u>  |  |                                    |  |  |  |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 22b. DATE THEREOF <u>JAN. 1960</u> |  | 22c. NAME OF CEMETERY OR CREMATORY <u>EAST VIEW CEM.</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>SALEM, NEW JERSEY</u> |  |  |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>254 CARROLL ST NW D.C.</u>  |  |                                    |  | 24a. REC'D BY REGISTRAR <u>JAN 11 1960</u> DATE  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krams</u>                      |  |  |  |   |  |

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

CERTIFICATE OF DEATH

No. 1000

DECEASED

NAME

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of Town Clerk

Signature of Village Clerk

Signature of Ward Clerk

Signature of Precinct Clerk

Signature of Polling Place Clerk

Signature of Election Officer

Signature of Returning Officer

0947  
CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                     |   |   |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                     | c. LENGTH OF STAY IN 1b<br><b>5 hrs.</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Suburban Hospital</b>   |                                     | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Rebecca</b> Middle <b>Jean</b> Last <b>Nieves</b>  |                                     | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>20</b> Year <b>19 60</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/10/58</b>   |
| 9. AGE (In years last birthday)<br><b>14 mos.</b>  |                                     | 10. IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>10</b> Hours <b></b> Min. <b></b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b></b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Luis Nieves</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>ELISA Pacheco</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b></b>  |   |
| 17. INFORMANT<br><b>Father Same as above</b>   |                                     | Address<br><b></b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Toxic myocarditis</b><br>571.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Acute enteritis</b><br>DUE TO<br>(c) <b></b> |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>4 days</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Menigitis</b>  |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b></b>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b></b>  |                                     | 20f. (City or town) (County) (State)<br><b></b>   |   |
| 21. I certify that I attended the deceased from <b>Jan. 19, 1960</b> to <b>Jan. 20, 1960</b> ; that I last saw the deceased alive on <b>Jan. 20, 1960</b> , and that death occurred at <b>11:53 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b></b> DATE SIGNED <b>1-20-60</b> |                                     |   |   |
| ACTUAL SIGNATURE <b>Philip H. Varner</b> M.D.  |                                     | <b></b>   |   |
| PHYSICIAN'S NAME (Type) <b>Philip Varner</b>   |                                     | <b></b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 22b. DATE THEREOF<br><b>1/22/60</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN CEMETERY</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>MONTGOMERY COUNTY, MARYLAND</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PUMPHREY, INC.</b><br><b>Raymond A. Ziska</b>   |                                     | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 25 '60</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>                                 |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

0838

|  |                                  |  |   |   |   |   |  |
|--|----------------------------------|--|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u> ✓ |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>   |                                  |  |   | c. LENGTH OF STAY IN 1b <u>15 hrs.</u>  |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital 1351 Langley Way</u>  |                                  |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Emile Walter Oeschger</u>  |                                  |  | 4. DATE OF DEATH Month Day Year<br><u>Jan 27 1960</u> |   |   |   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>6/30/88</u>                    | 9. AGE (In years last birthday)<br><u>71</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Months Days Hours Min.            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Accountant</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Switzerland</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>           |  |
| 13. FATHER'S NAME<br><u>Anton Oeschger</u>   |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Gertrude Hollenger</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO.<br><u>Pl's Chart</u>   |   | INFORMANT Address   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA, ACUTE</u><br><u>443x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Congestive Heart Failure</u><br>DUE TO (c) <u>Hypertensive Cardiovascular Disease</u> |                                  |  |   |   |   |   |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs.</u><br><u>48 hrs.</u><br><u>5 years</u>   |                                  |  |   |   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>  |                                  |  |   |   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                  |  |
| 21. I certify that I attended the deceased from <u>Jan. 27</u> , 19 <u>58</u> , to <u>Jan. 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan. 27</u> , 19 <u>60</u> , and that death occurred at <u>3:34 P.M.</u> , from the causes and on the date stated above.   |                                  |  |   |   |   |   |  |
| ACTUAL SIGNATURE <u>James L. Laubach</u> M.D.  |                                  |  |   | ADDRESS (Street, city or town, state) DATE SIGNED<br><u>1806 FOX ST. Hyattsville MD</u>   |   |   |  |
| PHYSICIAN'S NAME (Type) <u>JAMES L. LAUBACH</u>  |                                  |  |   | <u>Hyattsville MD</u>   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 22b. DATE THEREOF  |   | 22c. NAME OF CEMETERY OR CREMATORY  |   | 22d. LOCATION (City, town, or county) (State)         |  |
| <u>CREMATION</u>   |                                  | <u>Jan. 30, 1960</u>   |   | <u>Fort Lincoln Crematory</u>   |   | <u>Prince George Co. Md.</u>                          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>E. J. Walter Walter 254 Carroll St. NW</u>  |                                  |  |   | 24. REC'D BY REGISTRAR<br>DATE <u>JAN 29 '60</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Thomas</u> |  |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF MICHIGAN LIBRARY

346

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00920

Reg. Dist. No.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <span style="float: right;">0833</span><br>MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>11 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hosp.</u>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Montg</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>d. STREET ADDRESS <u>18400 Barron St.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>Mrs. Emily</u> <span style="float: right;">075</span><br>First Middle Last<br><b>4. DATE OF DEATH</b> <u>Jan.</u> <u>25</u> <u>1960</u><br>Month Day Year   |  |  |  | <b>5. SEX</b> <u>Female</u><br><b>6. COLOR OR RACE</b> <u>White</u><br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1-18-66</u><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>94</u> yrs.<br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u><br><b>11. BIRTHPLACE</b> (State or foreign country) <u>Pa</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> |  |   |  |
| <b>13. FATHER'S NAME</b> <u>Robert Knox</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Watson</u>  |  |  |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u><br><b>16. SOCIAL SECURITY NO.</b> <u>                    </u><br><b>17. INFORMANT</b> <u>Hospital Records</u> Address <u>                    </u>  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cephalic due to rupture of membranes + stomach contents</u><br>DUE TO <u>903.0</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumo-pneumonia</u><br>DUE TO <u>Fracture of rt hip</u><br>(c) <u>                    </u>  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>12 days</u> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interic scoliotic kidney disease</u><br><b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Fall on floor at home</u><br><b>20c. TIME OF INJURY</b> Month, Day, Year <u>1-13 1960</u><br>Hour a. m. <u>8:00</u> p. m. <u>                    </u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u><br><b>20f. (City or town)</b> <u>Takoma Pk</u> (County) <u>Montg</u> (State) <u>Md</u> |  |  |  |  |  |   |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>   |  |  |  |  |  |   |  |
| <b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> <b>M.D.</b><br><b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u>  |  |  |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>   |  |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>  |  | <b>22b. DATE THEREOF</b> <u>JAN 28, 1960</u>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. David's Cemetery</u>  |  |   |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Walter Funeral Home</u>  |  | <b>ADDRESS</b> <u>254 Canal St. Nt</u>   |  | <b>24a. REC'D BY REGISTRAR</b> <u>JAN 27 '60</u> <b>DATE</b>   |  |   |  |
| <b>24b. REGISTRAR'S SIGNATURE</b> <u>                    </u>   |  | <b>24c. LOCATION (City, town, or county)</b> <u>Prince George County</u> (State) <u>Md</u> |  |  |  |   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-CARLISLE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| NAME OF DECEASED<br>LAST, FIRST, MIDDLE<br>SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE<br>AGE <input type="text"/> YEARS <input type="text"/> MONTHS <input type="text"/> DAYS<br>DATE OF BIRTH <input type="text"/> |  | PLACE OF BIRTH<br>STATE <input type="text"/> COUNTRY <input type="text"/> |  |
| OCCUPATION<br><input type="text"/>   |  | PLACE OF DEATH<br><input type="text"/>                                    |  |
| MARITAL STATUS<br><input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED<br>DATE OF MARRIAGE <input type="text"/>   |  | RACE<br><input type="text"/>  |  |
| RELIGION<br><input type="text"/>   |  | EDUCATION<br><input type="text"/>   |  |
| PRESENT ADDRESS<br><input type="text"/>  |  | DATE OF DEATH <input type="text"/>  |  |
| CAUSE OF DEATH<br><input type="text"/>   |  | MANNER OF DEATH<br><input type="text"/>                                   |  |
| MEDICAL HISTORY<br><input type="text"/>  |  | SOCIAL HISTORY<br><input type="text"/>                                    |  |
| PHYSICAL EXAMINATION<br><input type="text"/>   |  | LABORATORY TESTS<br><input type="text"/>                                  |  |
| SIGNATURE OF EXAMINER<br><input type="text"/>  |  | SIGNATURE OF WITNESS<br><input type="text"/>                              |  |
| DATE OF EXAMINATION <input type="text"/>   |  | PLACE OF EXAMINATION <input type="text"/>                                 |  |

MASSACHUSETTS DEPARTMENT OF HEALTH-CARLISLE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
0949  
CERTIFICATE OF DEATH

00921

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>4 years</u>   |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>5611 Jordan Road</u>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>SUSANNA TATE OSBODD</u>   |  |   |  | 4. DATE OF DEATH Month Day Year<br><u>JAN 10 1960</u>   |  |  |   |
| 5. SEX<br><u>FEMALE</u>   |  | 6. COLOR OR RACE<br><u>WHITE</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Dec. 30 1868</u>                              |   |
| 9. AGE (In years lost birthday)<br><u>91</u> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | 11. IF UNDER 24 HRS.<br>Months Days Hours Min.  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>US</u>                            |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Pennsylvania</u>     |   |
| 13. FATHER'S NAME<br><u>Miles W. Tate</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Catherine McGee</u>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT Address<br><u>Mrs. DuVall-daughter-same as 2d</u>   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost.<br>(b) <u>Cerebral Arteriosclerosis</u><br>DUE TO<br>(c) _____ |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br>19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                 |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> 19 to <u>1/10</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>1/10</u> 19 <u>60</u> , and that death occurred at <u>3:30 AM</u> from the causes and on the date stated above.  |  |   |  |   |  |  |   |
| 22a. SIGNATURE<br><u>Lawrence A. Rapee</u> M.D.   |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22b. DATE SIGNED<br><u>1/10/1960</u>                                 |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>LAWRENCE A. RAPEE</u>  |  |   |  | 22d. ADDRESS<br><u>1150 CONN AVE N.W. D.C.</u>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Bur-Transit</u>   |  | 23b. DATE THEREOF<br><u>1/12/60</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Morris Hill Cemetery</u>   |  | 23d. LOCATION (City, town, or county) (State)<br><u>Boosi, Idaho</u> |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey</u>   |  |   |  | ADDRESS<br><u>Bethesda, Maryland</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 14 '60</u>                    |   |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |  |  |   |

MEDICAL CERTIFICATION



0950

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>4 days</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital Bethesda, Md.</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Harry</b> Middle <b>Gates</b> Last <b>PATRICK</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>19</b> Year <b>19 60</b>  |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Caucasian</b>      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>6-4-89</b>  |  |
| 9. AGE (In years last birthday)<br><b>70 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U.S. Naval Service</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Officer U.S. Navy</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Indiana</b>                |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>William Patrick</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Louise Dixon</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |  |   |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>1908 -</b>   |  |  |  |
| 17. INFORMANT<br><b>Mrs. Robert Williams (D)</b>  |  |   |  | Address<br><b>3902 Woodbine Ave. Chevy Chase, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO<br>(c) <b>3 days</b><br><b>10 yrs</b> |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Duodenal ulcer</b>   |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)     |  |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>January 16, 1960</b> , to <b>January 19, 1960</b> that I last saw the deceased alive on <b>January 19, 1960</b> , and that death occurred at <b>0310 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>F. J. Linehan Jr.</b>   |  |   |  | M.D. <b>U.S. Naval Hospital,</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>F. J. LINEHAN JR. LCDR MC USN</b>  |  |   |  | <b>Bethesda, Maryland</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>1-22-60</b>       |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b> ADDRESS <b>Bethesda, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 21 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur E. Farnham</b>                        |  |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF JUSTICE

Washington, D.C.

January 12, 1960

Mr. J. Edgar Hoover

Director

Re: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00923

0866 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>23 years</b>  |  |   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |  |   |  | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>3505 Farragut Avenue</b>   |  |   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  | d. STREET ADDRESS<br><b>3505 Farragut Avenue</b>  |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Peters</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>5</b> Year <b>19 60</b>   |  |   |   |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>                  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 17, 1885</b>   |   |
| 9. AGE (In years last birthday)<br><b>74</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>18</b> |  | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>  |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Penna.</b>                        |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |   |   |
| 13. FATHER'S NAME<br><b>John William Davis</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Evans</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | INFORMANT Address<br><b>Item #2</b><br><b>Constance N. Peters-Daughter-in-Law</b> |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b><br>151X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO<br>(c)  |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr</b>                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>  |  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)            |   |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |   |   |
| 21. I certify that I attended the deceased from <b>Feb</b> , 19 <b>59</b> , to <b>Jan 5</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Jan 4</b> , 19 <b>60</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>George Sharpe</b> M.D. <b>10511 Summit Ave Jan 6 1960</b><br>ACTUAL SIGNATURE<br><b>George Sharpe</b> <b>Kensington Md</b><br>PHYSICIAN'S NAME (Type) |  |   |  |   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>1-8-60</b>                |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>German Prot. Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Morea, Penna.</b>             |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 7 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Knap</b>                               |   |

DEATH CERTIFICATE OF DEATH

Montgomery

ARRIVALSON

3000 PATTERSON AVENUE

January 2

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## 0840 CERTIFICATE OF DEATH

Reg. Dist. No.

00924

|   |                               |  |                                 |   |  |   |                       |
|---|-------------------------------|--|---------------------------------|---|--|---|-----------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               |  |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |   |                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>  |                               |  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>                                      |  |   |                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>  |                               |  |                                 | d. STREET ADDRESS <u>2715 Plyers' Mill Rd.</u>  |  |   |                       |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>William Warner Poole</u>   |                               |  |                                 | 4. DATE OF DEATH Month Day Year <u>Jan. 27 1960</u>   |  |   |                       |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/8/96</u> |   | 9. AGE (In years last birthday) <u>63</u> yrs. | IF UNDER 1 YEAR Months Days Hours   | IF UNDER 24 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker - Continental Baking Co. Md.</u>   |                               |  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) <u>Am.</u>                            |                       |
| 13. FATHER'S NAME <u>WARNER</u>   |                               |  |                                 | 14. MOTHER'S MAIDEN NAME <u>Ella King</u>   |  |   |                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                               |  |                                 | 16. SOCIAL SECURITY NO. <u>Pt.'s Chart</u>  |  | INFORMANT Address   |                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION, ACUTE</u> DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GLOMERULONEPHRITIS, CHRONIC</u> |                               |  |                                 |   |  |   |                       |
| INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>  |                               |  |                                 |   |  |   |                       |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                 |   |  |   |                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |                       |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |                               |  |                                 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>               |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)          |                       |
|   |                               |  |                                 | 20f. (City or town) (County) (State)  |  |   |                       |
| 21. I certify that I attended the deceased from <u>March</u> , 19 <u>53</u> , to <u>January 27</u> 19 <u>60</u> that I last saw the deceased alive on <u>Jan. 27</u> , 19 <u>60</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above.   |                               |  |                                 |   |  |   |                       |
| ACTUAL SIGNATURE <u>James A. Roberts</u> M.D.   |                               |  |                                 | ADDRESS (Street, city or town, state) <u>8907 GEORGIA AVENUE</u> DATE SIGNED <u>1/27/60</u>   |  |   |                       |
| PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>   |                               |  |                                 | <u>SILVER SPRING, MARYLAND</u>  |  |   |                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                               | 22b. DATE THEREOF <u>1/30/60</u>   |                                 | 22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGES COUNTY, MD.</u> |                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>  |                               |  |                                 | 24a. REC'D BY REGISTRAR <u>Jan 29 '60</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>                              |                       |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

*[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]*

## 0951 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |  |  |   |  |  |
|--|---|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |   |   |  | c. LENGTH OF STAY IN 1b<br><b>1 1/2 days</b>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Suburban</b>  |   |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Raymond</b> Middle <b>Lynwood</b> Last <b>Pope</b>   |   |   |  | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>5</b> Year <b>1960</b>   |   |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/9/03</b>  | 9. AGE (In years last birthday)<br><b>56</b> yrs.  | IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>26</b> | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - Nurse</b>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>No. Carolina</b>                     |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>        |  |  |
| 13. FATHER'S NAME<br><b>Herbert Pope</b>   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Daisy Williams</b>                            |  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |   | 16. SOCIAL SECURITY NO.<br><b>Navy</b>  |  | 16. SOCIAL SECURITY NO. <b>Unknown</b>   |   |  | INFORMANT Address<br><b>(wife) Mrs. Agatha Pope (same as item 2)</b> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>coronary occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b></b> DUE TO (c) <b></b>  |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>congestive heart failure</b>  |   |   |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br><b></b>   | (County)<br><b></b>  | (State)<br><b></b>                                |  |  |
| 21. I certify that I attended the deceased from <b>July 18, 1956</b> to <b>Jan. 5, 1960</b> that I last saw the deceased alive on <b>Jan. 4, 1960</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>615 W. Montgomery Ave. Rockville, Md.</b> DATE SIGNED <b>1-5-60</b> |   |   |  |  |   |  |  |
| ACTUAL SIGNATURE <b>Stephen C. Cromwell</b> M.D.   |   |   |  |  |   |  |  |
| PHYSICIAN'S NAME (Type) <b>STEPHEN C. CROMWELL</b>   |   |   |  |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial-transit</b>   | 22b. DATE THEREOF<br><b>1-6-60</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Hill Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Warren County, N. C.</b> |  |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>ROBERT A. PUMPHREY</b>  |   |   | ADDRESS<br><b>Bethesda, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 7 '60</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hume</b>  |  |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |  |  |  |  |   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|--|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> <span style="float: right;"><b>MARYLAND</b></span><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring,</b><br>NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Whitmoor Terrace, 242 Whitmoor Terrace,</b>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Maryland</b> <span style="float: right;"><b>Montgomery</b></span><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring,</b><br>d. STREET ADDRESS<br><b>Whitmoor Terrace, 242 Whitmoor Terrace</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |  |  |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>Allan Singleton Potter</b>   |  | <b>4. DATE OF DEATH</b><br>Month <b>January</b> Day <b>19</b> Year <b>1960</b> |  | <b>5. SEX</b><br><b>Male</b>   |  | <b>6. COLOR OR RACE</b><br><b>White</b>   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><b>Oct 29, 1925</b>   |  | <b>9. AGE</b> (In years last birthday) <b>34</b> yrs.<br>IF UNDER 1 YEAR: Months _____ Days _____<br>IF UNDER 24 HRS.: Hours _____ Min. _____ |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Painter</b>  |  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Contractor</b>  |  |   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Baltimore, Maryland</b>   |  |  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  |
| <b>13. FATHER'S NAME</b><br><b>Wilber Potter</b>  |  |  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Virginia Singleton</b>  |  |  |  |  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give year or dates of service)<br><b>Yes WW 2</b>   |  |  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>212-20-4169</b>   |  |   |  | <b>17. INFORMANT</b><br>Address<br><b>Mrs. Ruby B. Potter C-11 Presidential Garden Apt.</b>  |  |  |  |   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hanging</b><br>9774X DUE TO _____<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } DUE TO _____<br>(c) _____  |  |  |  |  |  |   |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____  |  |  |  |  |  |   |  |  |  |  |  |   |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>  |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>(Deceased missing since Jan. 19, 1960; body discovered October 1, 1962.)</b>   |  |   |  |  |  |  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <b>Jan. 1960</b><br>p.m. _____   |  |  |  | <b>20d. INJURY OCCURRED</b><br>While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>  |  |   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>attic, 242 Whitmoor Terrace, Silver Spring, Montg. Md.</b>                     |  |  |  |   |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b><br>Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |  |  |  |  |   |  |
| <b>ACTUAL SIGNATURE</b><br><b>John G. Ball</b>  |  |  |  |  |  | <b>DATE SIGNED</b><br><b>10/1/62</b>  |  |  |  |  |  |   |  |
| <b>EXAMINER'S NAME</b> (Type)<br><b>John G. Ball</b>  |  |  |  |  |  | <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) _____ |  |  |  |  |  |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Cremation</b>  |  |  |  | <b>22b. DATE THEREOF</b><br><b>Oct 2, 1962</b>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Fort Lincoln Crematory</b>  |  |  |  | <b>22d. LOCATION</b> (City, town, or county) (State)<br><b>Prince George's Maryland</b>                  |  |   |  |
| <b>23. FUNERAL DIRECTOR</b><br><b>Raymond A. Ziska</b><br><b>Warner E. Pumphrey, Inc., Silver Spring, Md.</b>   |  |  |  |  |  | <b>24a. REC'D BY REGISTRAR</b><br><b>OCT 4 1962</b><br><b>DATE</b>  |  |  |  |  |  |   |  |

MEDICAL CERTIFICATION





0952

## CERTIFICATE OF DEATH

00926

Reg. Dist. No.

|   |                                    |   |   |  |   |
|---|------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |                                    |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OLNEY</b>  |                                    |   | c. LENGTH OF STAY IN 1b<br><b>L6 HRS.</b>   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>   |                                    |   | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>REAZION</b> Middle <b>JOSEPH</b> Last <b>PRATHER</b>  |                                    |   | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>28</b> Year <b>1960</b>   |  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>COLORED</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAR. 4, 1880</b>   |  | 9. AGE (In years last birthday)<br><b>79</b> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>WAITER</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b> |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                    |   | 13. FATHER'S NAME<br><b>LEVI PRATHER</b>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>MARTHA SIMPSON</b>   |                                    |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |  |   |
| 16. SOCIAL SECURITY NO.<br><b>HOSPITAL RECORDS</b>  |                                    |   | Address<br><b>OLNEY, MD.</b>  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b><br><b>491X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Acute pulmonary edema</b><br>(c) <b>Chronic Pyelonephritis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                    |   |   |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                    |   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                                    |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                    |   | 20f. (City or town) (County) (State)  |  |   |
| 21. I certify that I attended the deceased from <b>Jan 21, 1960</b> to <b>Jan 28, 1960</b> , that I last saw the deceased alive on <b>Jan 28, 1960</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.  |                                    |   |   |  |   |
| ACTUAL SIGNATURE <b>Luciano L. Leal</b> M.D.  |                                    |   | ADDRESS (Street, city or town, state) <b>Gaithersburg, Md.</b>  |  |   |
| PHYSICIAN'S NAME (Type) <b>Luciano L. Leal</b>  |                                    |   | DATE SIGNED   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                    | 22b. DATE THEREOF<br><b>2/1/60</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Brooke Grove.,</b>  |   |
| 22d. LOCATION (City, town, or county) (State)<br><b>Laytonsville, Md.</b>   |                                    |   |   |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert L. Swarden</b>  |                                    |   | ADDRESS<br><b>Bookville, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>FEB 5 '60</b>       |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |                                    |   |   |  |   |

1

Page 4

death. Page 4

24 hours

the law requires that the death certificate be executed within 24 hours

the attending physician and completely filled in by the funeral director,

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)

ISM 9/58

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Levy, J. 1993.

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## Reg. Dist. No.

### MEDICAL CERTIFICATION

0813 CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00928

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural-Darnestown</b><br>c. LENGTH OF STAY IN lb<br><b>69X-3</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>New York City</b><br>b. COUNTY<br><b>New York</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>New York</b><br>d. STREET ADDRESS<br><b>125 Hudson Terrace</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>WILLIAM COWPER PRIME</b><br>First Middle Last  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>January 30 1960</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>Oct. 21, 1870</b> |
| 9. AGE (In years last birthday)<br><b>89</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>3 9</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret.</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Lawyer</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Yonkers, New York</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Ralph E. Prime</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Annie Woolcott</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>Benj. L. Prime</b>   |                                  | 18. ADDRESS<br><b>131 E. 66th. St. New York, N.Y.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>446X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteriosclerotic Renal disease</b><br>(c) <b>Arteriosclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>2 years</b><br><b>4 years</b>                     |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>ADVANCED AGE</b>  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Nov. 1955</b> to <b>January 3, 1960</b> , that I last saw the deceased alive on <b>29 Jan. 1960</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>DAWSONVILLE</b> DATE SIGNED <b>30 Jan 60</b><br>ACTUAL SIGNATURE <b>John G. Fawcett</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>JOHN FAWCETT</b> <b>Boys, Md.</b> |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Crementation</b>   |                                  | 22b. DATE THEREOF<br><b>2/1/60</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Prince George Co., Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Tyson Wheeler Funeral Home</b>  |                                  | 24. REC'D BY REGISTRAR<br><b>Rockville, Md.</b> DATE <b>FEB 1 '60</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. K...</b>  |                                  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove-carban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF ALABAMA  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1935

NAME OF DECEASED  
SEX  
AGE  
DATE OF BIRTH  
PLACE OF BIRTH  
OCCUPATION  
CAUSE OF DEATH  
MANNER OF DEATH  
PLACE OF DEATH  
DATE OF DEATH  
TIME OF DEATH  
SIGNATURE OF REGISTRAR  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF MINISTER OF THE GOSPEL  
SIGNATURE OF JURY  
SIGNATURE OF CORONER

NAME OF DECEASED  
SEX  
AGE  
DATE OF BIRTH  
PLACE OF BIRTH  
OCCUPATION  
CAUSE OF DEATH  
MANNER OF DEATH  
PLACE OF DEATH  
DATE OF DEATH  
TIME OF DEATH  
SIGNATURE OF REGISTRAR  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF MINISTER OF THE GOSPEL  
SIGNATURE OF JURY  
SIGNATURE OF CORONER



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00929

Reg. Dist. No.

0816

FOR STATE  
HEALTH DEPT.

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>56 SILVER SPRING</b>  |   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>8011 EASTERN AVENUE Apt. 105</b>  |                                  |   | d. STREET ADDRESS<br><b>8011 EASTERN AVE., APT. 105</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br><b>ROSE B. PROPER</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>JAN.</b> Day <b>29</b> Year <b>19 60</b>   |  |   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JULY 19, 1901</b>  |  | 9. AGE (in years last birthday)<br><b>58</b> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOMEMAKER</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>NEW YORK</b>   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13. FATHER'S NAME<br><b>ISADORE COHEN</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>NELLIE</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>219-05-1915</b>   |   | 17. INFORMANT<br>Address<br><b>Mr. B. H. Goldstein, 111 Lee Ave. Takoma Park, Md.</b>                          |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____      |                                  |   |   |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |   |  |   |
| ACTUAL SIGNATURE<br><i>Frank J. Broschart</i>  |                                  | EXAMINER'S NAME (Type)<br><b>Frank J. Broschart</b>   |   | DATE SIGNED<br><b>Jan. 29, 1960</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>FEB. 1, 1960</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW CEMETERY BALTIMORE Md.</b>                           |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>B. Langusky &amp; Sons</i>  |                                  | ADDRESS<br><b>3501-14 ST. NW.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 3 '60</b>   |   |
|  |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur L. Kraya</i>   |   |

MEDICAL CERTIFICATION

TO DEPUTY CHIEF OF HEALTH DEPT.: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Registrar. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

00930

0841

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY Co.,</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>TAKOMA PARK</u>                    |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ELLICOTT CITY</u> <u>13X-2</u>                     |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>WASHINGTON SANITARIUM AND HOSPITAL</u> |  | d. STREET ADDRESS<br><u>RFD 4</u>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  |   |  |

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <u>BABY GIRL</u> Middle <u>PUCILOSKI</u> Last <u>PUCILOSKI</u>         |                                  | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>3</u> Year <u>1960</u>   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1-1-60</u>                            |
| 9. AGE (In years last birthday) yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>7</u> Hours <u>7</u> Min.   | 11. IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>NONE</u>          |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>NONE</u>   | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u> |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                  |  |  |
| 13. FATHER'S NAME<br><u>John Puciloski</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>SHIRLEY GUPTON</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) |                                  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>   |  |
| 17. INFORMANT<br><u>JOHN PUCILOSKI</u>  |                                  | Address<br><u>RFD 4, ELLICOTT CITY, MD.</u>  |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>LACK OF EXPANSION OF LUNGS</u><br><u>762.5</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PREMATURITY</u><br>DUE TO (c) _____ |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>SINCE BIRTH</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

|  |  |  |                                      |
|--|--|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |                                      |
| 20c. TIME OF INJURY<br>Hour <u>a. m.</u> Month, Day, Year <u>19</u><br>p. m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       | 20f. (City or town) (County) (State) |

21. I certify that I attended the deceased from 1-1, 1960, to 1-3, 1960, that I last saw the deceased alive on 1-3, 1960, and that death occurred at 1:45 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) M.D. 6811 Ridge Rd., Hyattsville, Md. DATE SIGNED 1-3-60

ACTUAL SIGNATURE Mary K. L. Sartwell

PHYSICIAN'S NAME (Type) \_\_\_\_\_

|  |                                    |   |  |
|--|------------------------------------|---|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                       | 22b. DATE THEREOF<br><u>1-5-60</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>ST LOUIS</u> | 22d. LOCATION (City, town, or county) (State)<br><u>CLARKSVILLE, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>F.C. HIGGINS BOTHOM, ELLICOTT CITY MD</u> |                                    | 24a. REC'D BY REGISTRAR<br><u>JAN 6 '60</u>           | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>                     |

2075332XU1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| NAME OF DECEASED<br>[Handwritten: John Doe]            |  | SEX<br>[Handwritten: Male]                       |  | AGE<br>[Handwritten: 45]                              |  |
| DATE OF DEATH<br>[Handwritten: Jan 15, 1945]           |  | TIME OF DEATH<br>[Handwritten: 10:30 AM]         |  | PLACE OF DEATH<br>[Handwritten: Home]                 |  |
| CAUSE OF DEATH<br>[Handwritten: Myocardial Infarction] |  | MANNER OF DEATH<br>[Handwritten: Natural]        |  | PLACE OF BURIAL<br>[Handwritten: St. Mary's Cemetery] |  |
| SIGNATURE OF PHYSICIAN<br>[Handwritten: Dr. J. Smith]  |  | SIGNATURE OF DECEASED<br>[Handwritten: John Doe] |  | SIGNATURE OF WITNESS<br>[Handwritten: Mary Doe]       |  |
| SIGNATURE OF REGISTRAR<br>[Handwritten: J. Doe]        |  | SIGNATURE OF CLERK<br>[Handwritten: M. Doe]      |  | SIGNATURE OF JURY<br>[Handwritten: J. Doe]            |  |

This certificate is to be filled out by the physician or other person authorized by the State Department of Health. It is to be filed in the office of the Registrar of the State Department of Health. The Registrar will issue a certificate of death to the family of the deceased. The certificate of death is a legal document and must be kept for a period of ten years.

0867

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                               |  |                                    |  |                 |  |  |
|---|-------------------------------|--|------------------------------------|--|-----------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b>  |                               |  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>DC</u> b. COUNTY <u>✓</u> |                 |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>  |                               | c. LENGTH OF STAY IN 1b  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>                |                 | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Garden Conv. Home</u>  |                               |  |                                    | d. STREET ADDRESS <u>5736 44th St NW</u>   |                 |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE ALEXANDER PUGH</u>  |                               |  |                                    | 4. DATE OF DEATH Month Day Year <u>Jan 4 1960</u>  |                 |  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 9 1883</u> | 9. AGE (In years last birthday) <u>76</u> yrs.   | IF UNDER 1 YEAR | IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                    | 11. BIRTHPLACE (State or foreign country) <u>Va</u>  |                 | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME <u>Charles Pugh</u>   |                               |  |                                    | 14. MOTHER'S MARDEN NAME <u>Eliza Phillips</u>   |                 |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                               | 16. SOCIAL SECURITY NO. <u>331X</u>  |                                    | INFORMANT <u>Shirley A Pugh</u> Address <u>5232-40th St NW DC</u>  |                 |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u><br>DUE TO (c) |                               |  |                                    |  |                 |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |  |                                    |  |                 |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |  |                 |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                 | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>October 5, 1959</u> to <u>Jan 4, 1960</u> , that I last saw the deceased alive on <u>Jan 4, 1960</u> , and that death occurred at <u>1:35 PM</u> from the causes and on the date stated above.   |                               |  |                                    |  |                 |  |  |
| ACTUAL SIGNATURE <u>P. P. Andrews</u>   |                               | ADDRESS (Street, city or town, state) <u>4201 Farnsworth St NW 1-4-60</u>  |                                    |  |                 |  |  |
| PHYSICIAN'S NAME (Type) <u>P. P. ANDREWS</u>  |                               | DATE SIGNED <u>Washington DC</u>   |                                    |  |                 |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>   |                               | 22b. DATE THEREOF <u>1/6/60</u>  |                                    | 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>   |                 | 22d. LOCATION (City, town, or county) (State) <u>Rockville Md</u>                      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas E. M. Ford Home</u>  |                               | ADDRESS <u>5103 Van Ness St NW</u>   |                                    | 24a. REC'D BY REGISTRAR <u>DATE JAN 7 '60</u>  |                 | 24b. REGISTRAR'S SIGNATURE <u>Charles S. K...</u>                                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

RECEIVED

NOV 10 1911

1911





## 0842 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1. PLACE OF DEATH<br>a. CITY <u>Montgomery</u> MARYLAND   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>—</u> b. COUNTY <u>—</u> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |   |  | c. LENGTH OF STAY IN 1b <u>35 hours</u>   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>   |   |  | d. STREET ADDRESS <u>D. C. 478-3</u>  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |   |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Fannie Elizabeth Rakow</u>   |   |  | 4. DATE OF DEATH <u>January 24 1960</u>   |  |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-10-1860</u>   |  | 9. AGE (In years lost birthday) <u>99</u> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   | 11. BIRTHPLACE (State or foreign country) <u>Illinois</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |
| 13. FATHER'S NAME <u>Henry Parker</u>   |   |  | 14. MOTHER'S MAIDEN NAME <u>Jane Davis</u>  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |   |  | 16. SOCIAL SECURITY NO. <u>—</u>  |  |  |
| 17. INFORMANT <u>Hospital Records</u>   |   |  | Address <u>—</u>  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u><br>DUE TO (b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO (c) <u>—</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Two months exact time unknown</u><br><u>Several years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)   | (County)   | (State)  |
| 21. I certify that I attended the deceased from <u>1-19</u> , 19 <u>60</u> , to <u>1-24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-23</u> , 19 <u>60</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.   |   |  |   |  |  |
| ACTUAL SIGNATURE <u>Stuart L. Nelson</u>  |   | ADDRESS (Street, city or town, state) <u>7600 Carroll Avenue, Takoma Park Md. 42-1/60</u>  |   |  |  |
| PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>   |   | DATE SIGNED <u>—</u>   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>  | 22b. DATE THEREOF <u>1/25/60</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Cemetery</u>  |   | 22d. LOCATION (City, town, or county) (State) <u>Oskaloosa, Iowa</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>  |   | ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>   |   | 24a. REC'D BY REGISTRAR <u>—</u>                                     | 24b. REGISTRAR'S SIGNATURE <u>—</u>  |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1920

(1)

Harvey Parker

Harvey Parker

Harvey Parker

Harvey Parker

Harvey Parker

0868

CERTIFICATE OF DEATH

00933

Reg. Dist. No.

|   |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>MONTGOMERY</i>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>KENNSINGTON</i> |  | c. LENGTH OF STAY IN lb<br><i>26</i>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><i>Maryland</i><br>b. COUNTY<br><i>MONTGOMERY</i> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rockville</i>   |  | d. STREET ADDRESS<br><i>4605 STANFLEIGH CT.</i>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><i>Raymond — Rennebergen</i>   |  | 4. DATE OF DEATH<br>Month Day Year<br><i>1 11 1960</i>   |  | 5. SEX<br><i>Male</i>   |  | 6. COLOR OR RACE<br><i>white</i>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><i>3-6-79</i>  |  | 9. AGE (In years lost birthday) yrs.<br><i>80</i>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Railroad &amp; Transit Co. Retired.</i> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Maryland</i>   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 13. FATHER'S NAME<br><i>Robert Rennebergen</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Virginia Eaker</i>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><i>NO</i>                          |  |
| 16. SOCIAL SECURITY NO.<br><i>578-10-8128</i>   |  | 17. ADDRESS<br><i>Kennsington GARDENS SAUT. 3000 McComb Ave.</i>                                       |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocardial infarct</i><br><i>420.0</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> DUE TO<br>(c) <i>year</i> |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>year</i>  |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary thrombosis</i> |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><i>19</i>                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  | 21. I certify that I attended the deceased from <i>Jan 1</i> , 19 <i>57</i> , to <i>1/11</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1/12</i> , 19 <i>60</i> , and that death occurred at <i>1:30 P.M.</i> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <i>11116 DATE SIGNED</i> |  | 22. LOCATION (City, town, or county) (State)<br><i>Gaithersburg Md.</i>  |  |
| 21. ACTUAL SIGNATURE<br><i>Charles M. Weber, M.D.</i>   |  | 22. FUNERAL DIRECTOR'S SIGNATURE<br><i>W.W. Chambers Co.</i>   |  | 23. ADDRESS<br><i>1400 Chapin St. N.W.</i>  |  | 24a. REC'D BY REGISTRAR<br><i>DATE JAN 15 '60</i>  |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Hume</i>  |  | 25. DATE<br><i>JAN 15 '60</i>  |  | 26. REGISTRAR'S SIGNATURE<br><i>Arthur S. Hume</i>   |  |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Place of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Signature of medical officer: \_\_\_\_\_

10. Signature of registrar: \_\_\_\_\_

11. Date of registration: \_\_\_\_\_

12. Registrar's name: \_\_\_\_\_

13. Registrar's address: \_\_\_\_\_

14. Registrar's telephone: \_\_\_\_\_

15. Registrar's fax: \_\_\_\_\_

16. Registrar's email: \_\_\_\_\_

17. Registrar's website: \_\_\_\_\_

18. Registrar's mobile: \_\_\_\_\_

19. Registrar's home: \_\_\_\_\_

20. Registrar's work: \_\_\_\_\_

21. Registrar's other: \_\_\_\_\_

22. Registrar's notes: \_\_\_\_\_

23. Registrar's comments: \_\_\_\_\_

24. Registrar's remarks: \_\_\_\_\_

25. Registrar's observations: \_\_\_\_\_

26. Registrar's findings: \_\_\_\_\_

27. Registrar's conclusions: \_\_\_\_\_

28. Registrar's recommendations: \_\_\_\_\_

29. Registrar's suggestions: \_\_\_\_\_

30. Registrar's advice: \_\_\_\_\_

31. Registrar's instructions: \_\_\_\_\_

32. Registrar's orders: \_\_\_\_\_

33. Registrar's prescriptions: \_\_\_\_\_

34. Registrar's referrals: \_\_\_\_\_

35. Registrar's consultations: \_\_\_\_\_

36. Registrar's investigations: \_\_\_\_\_

37. Registrar's treatments: \_\_\_\_\_

38. Registrar's interventions: \_\_\_\_\_

39. Registrar's procedures: \_\_\_\_\_

40. Registrar's techniques: \_\_\_\_\_

41. Registrar's methods: \_\_\_\_\_

42. Registrar's approaches: \_\_\_\_\_

43. Registrar's strategies: \_\_\_\_\_

44. Registrar's plans: \_\_\_\_\_

45. Registrar's goals: \_\_\_\_\_

46. Registrar's objectives: \_\_\_\_\_

47. Registrar's outcomes: \_\_\_\_\_

48. Registrar's results: \_\_\_\_\_

49. Registrar's impact: \_\_\_\_\_

50. Registrar's contribution: \_\_\_\_\_

51. Registrar's role: \_\_\_\_\_

52. Registrar's responsibilities: \_\_\_\_\_

53. Registrar's duties: \_\_\_\_\_

54. Registrar's functions: \_\_\_\_\_

55. Registrar's tasks: \_\_\_\_\_

56. Registrar's activities: \_\_\_\_\_

57. Registrar's actions: \_\_\_\_\_

58. Registrar's behaviors: \_\_\_\_\_

59. Registrar's attitudes: \_\_\_\_\_

60. Registrar's values: \_\_\_\_\_

61. Registrar's beliefs: \_\_\_\_\_

62. Registrar's opinions: \_\_\_\_\_

63. Registrar's views: \_\_\_\_\_

64. Registrar's perspectives: \_\_\_\_\_

65. Registrar's insights: \_\_\_\_\_

66. Registrar's knowledge: \_\_\_\_\_

67. Registrar's skills: \_\_\_\_\_

68. Registrar's abilities: \_\_\_\_\_

69. Registrar's talents: \_\_\_\_\_

70. Registrar's strengths: \_\_\_\_\_

71. Registrar's weaknesses: \_\_\_\_\_

72. Registrar's limitations: \_\_\_\_\_

73. Registrar's constraints: \_\_\_\_\_

74. Registrar's challenges: \_\_\_\_\_

75. Registrar's opportunities: \_\_\_\_\_

76. Registrar's threats: \_\_\_\_\_

77. Registrar's risks: \_\_\_\_\_

78. Registrar's hazards: \_\_\_\_\_

79. Registrar's dangers: \_\_\_\_\_

80. Registrar's perils: \_\_\_\_\_

81. Registrar's dangers: \_\_\_\_\_

82. Registrar's dangers: \_\_\_\_\_

83. Registrar's dangers: \_\_\_\_\_

84. Registrar's dangers: \_\_\_\_\_

85. Registrar's dangers: \_\_\_\_\_

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94. Registrar's dangers: \_\_\_\_\_

95. Registrar's dangers: \_\_\_\_\_

96. Registrar's dangers: \_\_\_\_\_

97. Registrar's dangers: \_\_\_\_\_

98. Registrar's dangers: \_\_\_\_\_

99. Registrar's dangers: \_\_\_\_\_

100. Registrar's dangers: \_\_\_\_\_

0954  
CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OLNEY</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>4 HRS. 40 MIN.</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  | f. STREET ADDRESS<br><b>213 LEE ST. APT. 5</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Sandra Sue RINES</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>12</b> Year <b>1960</b>   |  |   |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>                      |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>1/12/60</b>            |  |
| 9. AGE (In years lost birthday) yrs.<br><b>40</b>  |  | 10. IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>40</b> |  | 11. IF UNDER 24 HRS.<br>Hours <b>4</b> Min. <b>40</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13. FATHER'S NAME<br><b>BILLY RICHARD RINES</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>JOANN HADDOCK</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b>   |  |   |  |
| 17. HOSPITAL RECORDS<br><b>OLNEY, MD.</b>  |  |   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>776x Prematurity - 6 months gestation</b><br>DUE TO (b) <b>Gain pregnancy</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>None</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>—</b> |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>  |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <b>1/12</b> , 19 <b>60</b> , to <b>1/12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/12</b> , 19 <b>60</b> , and that death occurred at <b>4:45A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Gaithersburg Md.</b> DATE SIGNED <b>1/12/60</b> |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>W. A. Linthicum</b> M.D.   |  |   |  | PHYSICIAN'S NAME (Type) <b>W. A. LINTHICUM, M. D.</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMAINS (Specify)  |  | 22b. DATE THEREOF                                     |  | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or county) (State) |  |
| <b>Burial</b>  |  | <b>1-13-60</b>  |  | <b>Forest Oak</b>   |  | <b>Gaithersburg Md.</b>                       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James H. Gantner</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>JAN 14 '60</b>  |  |   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>G. H. H. H.</b>   |  |   |  | 24c. REGISTRAR'S SIGNATURE<br><b>G. H. H. H.</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL OF DEATH

0000

FLATBERRY

FLATBERRY

OLNEY

OLNEY

OLNEY

OLNEY

OLNEY

Sandra

Sandra

WATER

WATER

JOHN

JOHN

JOHN

JOHN

*[Handwritten signature]*

Peter

1-12-6

Notary

Notary



## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |                                    |
|--|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OLNEY</b><br>c. LENGTH OF STAY IN lb<br><b>2 HRS. 38 MIN.</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RYKXXXXXXXX GAITHERSBURG</b><br>d. STREET ADDRESS<br><b>213 LEE STREET APT 5</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                    |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Sunday Lou RINES</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>JANUARY 12 19 60</b>  |                                    |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>1/12/60</b> |
| 9. AGE (In years last birthday) yrs.<br><b>2</b>   |                                  | 10. IF UNDER 1 YEAR Months Days<br><b>2 38</b>   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                    |
| 13. FATHER'S NAME<br><b>BILLY RICHARD RINES</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>JOANN HADDOCK</b>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b>  |                                    |
| 17. ADDRESS<br><b>HOSPITAL RECORDS OLNEY, MD.</b>  |                                  |  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>776X Prematurity - 6 month gestation</b><br>DUE TO (b) <b>Twins pregnancy</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b><br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that I attended the deceased from <b>1/12</b> , 19 <b>60</b> , to <b>1/12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/12/60</b> , 19 <b>60</b> , and that death occurred at <b>2:45 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>1/12/60</b><br>ACTUAL SIGNATURE <b>W. A. Linthicum</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>W. A. LINTHICUM, M. D.</b>  |                                  |  |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>1-13-60</b>  |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Oak</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Gaithersburg. Md</b>   |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Emmett B. Gartner, Gaithersburg, Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 14 '60</b>  |                                    |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                  |  |                                    |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 7/58

217321XUO

CERTIFICATE OF DEATH

1923

DECEASED

HARRIS

WINTERBURY

2 WILSON ST. NEW YORK

WINTER

215 1ST STREET, NEW YORK

MANHATTAN COUNTY GENERAL HOSPITAL

1923

WINTER

WINTER

WINTER

1923

1923

WINTER

WINTER

WINTER

WINTER

HOSPITAL RECORDS

WINTER

*WINTER*

WINTER

WINTER

WINTER

1923

1923

1923

WINTER

WINTER

1-13-20

WINTER

## CERTIFICATE OF DEATH

Reg. Dist. No.

00936

|  |   |   |   |   |   |  |   |
|--|---|---|---|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>   |   |   |   | c. LENGTH OF STAY IN 1b<br><b>11 yrs.</b>   |   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>2603 ARCOLA AVENUE</b>  |   |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ELMER</b> Middle <b>G.</b> Last <b>ROCKENBACH</b>  |   |   |   | 4. DATE OF DEATH<br>Month <b>JAN.</b> Day <b>30</b> Year <b>19 60</b>   |   |  |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/25/99</b>                     | 9. AGE (In years last birthday)<br><b>60</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PLATE PRINTER</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bureau of Engraving U.S. Gov't.</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>OHIO</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |   |
| 13. FATHER'S NAME<br><b>GEORGE ROCKENBACH</b>  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>ROSE FEIL</b>  |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |   | 16. SOCIAL SECURITY NO.<br><b>291-09-3280</b>   |   | 17. INFORMANT Address<br><b>Mrs. Kathryn L. Rockenbach, 2603 Arcola Ave. Silver Spring, Md.</b>   |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>491X</b> DUE TO <b>Pulmonary edema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Bilateral bronchopneumonia</b><br>(c) <b>1 week</b> |   |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Silver Spring</b>  | 20f. (City or town) (County) (State)<br><b>Thoud Md</b> |   |   |  |   |
| 21. I certify that I attended the deceased from <b>1/26/60</b> , 19 <b>60</b> , to <b>1/30</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/29/60</b> , 19 <b>60</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.   |   |   |   |   |   |  |   |
| ACTUAL SIGNATURE <b>Patrick C Jameson</b> M.D.   |   |   |   | ADDRESS (Street, city or town, state)<br><b>12020 Georgia</b>   |   | DATE SIGNED<br><b>1/30/60</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>PATRICK C. JAMESON</b>   |   |   |   | <b>Silver Spring Md</b>   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>TRANS. &amp; BURIAL 1/31/60</b>  |   | 22b. DATE THEREOF<br><b>1/31/60</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>GREENLAWN CEMETERY</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>COLUMBUS, OHIO</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PIMPHREY, INC.</b><br><b>Raymond A. Ziska</b>   |   |   |   | ADDRESS<br><b>SILVER SPRING, MD.</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 3 '60</b>                       |   |
|  |   |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>William L. Kneass</b>  |   |  |   |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11 yrs.

RESIDENT

U.S. GOVT.

CASE NO.

201-11111



# CERTIFICATE OF DEATH

|   |  |
|---|--|
| DEPARTMENT OF HEALTH - DISTRICT OF COLUMBIA<br>DIVISION OF VITAL RECORDS  |  |
| NAME OF DECEASED<br>JAMES MARGARET GORDON<br>SEX<br>FEMALE<br>DATE OF BIRTH<br>1-11-1917<br>PLACE OF BIRTH<br>VIRGINIA<br>OCCUPATION<br>- - - - -<br>RESIDENCE<br>10 - - - - -<br>PLACE OF DEATH<br>10 - - - - -<br>CAUSE OF DEATH<br>10 - - - - -<br>MANNER OF DEATH<br>10 - - - - -<br>DATE OF DEATH<br>1-31-1960<br>TIME OF DEATH<br>1:25 PM<br>PLACE OF DEATH<br>U. S. Naval Hospital<br>Bethesda, Md.<br>COUNTY<br>DISTRICT OF COLUMBIA<br>CITY<br>WASHINGTON, D. C. | NAME OF PHYSICIAN<br>JAMES MARGARET GORDON<br>SEX<br>FEMALE<br>DATE OF BIRTH<br>1-11-1917<br>PLACE OF BIRTH<br>VIRGINIA<br>OCCUPATION<br>- - - - -<br>RESIDENCE<br>10 - - - - -<br>PLACE OF DEATH<br>10 - - - - -<br>CAUSE OF DEATH<br>10 - - - - -<br>MANNER OF DEATH<br>10 - - - - -<br>DATE OF DEATH<br>1-31-1960<br>TIME OF DEATH<br>1:25 PM<br>PLACE OF DEATH<br>U. S. Naval Hospital<br>Bethesda, Md.<br>COUNTY<br>DISTRICT OF COLUMBIA<br>CITY<br>WASHINGTON, D. C. |



## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN lb<br><b>19 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>District of Columbia</b><br>b. COUNTY<br><b>Prince Georges</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b><br>d. STREET ADDRESS<br><b>7608 Atwood St., SE, Apt. 7</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First<br><b>Gale</b><br>Middle<br><b>Marie</b><br>Last<br><b>RUNYAN</b>  |  |   |  | 4. DATE OF DEATH<br>Month<br><b>January</b><br>Day<br><b>24</b><br>Year<br><b>1960</b>  |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Caucasian</b>      |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>8-11-55</b>   |  |
| 9. AGE (In years lost birthday)<br><b>4</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months<br><b>4</b> |  | 11. IF UNDER 24 HRS.<br>Days<br><b>4</b>  |  | 12. IF UNDER 24 HRS.<br>Hours<br><b>4</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- - - - -</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                                 |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Raymond T. RUNYAN</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Selina BATTEN</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |  |  |
| 17. INFORMANT<br><b>(F) Raymond T. Runyan, same as #2</b>  |  |   |  | Address   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malignant Embryoma</b><br><b>199.2</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs.</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       |  |
| 20f. (City or town)<br><b>Bethesda</b>   |  |   |  | 20g. (County)<br><b>Montgomery</b>  |  | 20h. (State)<br><b>Md.</b>   |  |
| 21. I certify that I attended the deceased from <b>January 5</b> , 19 <b>60</b> , to <b>January 24</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>January 24</b> , 19 <b>60</b> , and that death occurred at <b>7:40 AM</b> , from the causes and on the date stated above.   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>H. L. Walton</b>   |  |   |  | ADDRESS (Street, city or town, state)<br><b>U. S. Naval Hospital</b>  |  |  |  |
| DATE SIGNED<br><b>1-24-60</b>  |  |   |  |   |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>H. L. WALTON, LT, MC, USN</b>  |  |   |  | Bethesda 14, Maryland   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 22b. DATE THEREOF<br><b>1-25-60</b>       |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Wenonah Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Wenonah New Jersey</b>                   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>S.H. Hines</b>  |  |   |  | ADDRESS<br><b>2901 14th St., NW, WashDC</b>   |  | 24a. REC'D BY REGISTRAR<br><b>JAN 26 '60</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>   |  |   |  |   |  |  |  |

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Page 4

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

Division of Criminal Justice

Montgomery

Washington

19 days

between (Rural)

1968 Wood St., 22, 1968

U. S. Naval Hospital

RUMIN

Male

Colo

8-11-52

I

Continued

Female

Virginia

- - - - -

None

Colin RUMIN

Raymond T. RUMIN

(T) Raymond T. RUMIN, same as 12

None

No

Raymond T. RUMIN

January 24-1968

January 2

January 24

1:40A

1-24-68

U. S. Naval Hospital

Section 14, Maryland

H. L. WILSON, Jr., MD, USA

New Jersey

Verona

Verona Community

1-25-68

Verona

H. L. Wilson, MD, USA, 14th St., N.W., Washington

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Page 4  
after 24 hours after death, by the funeral director, and completely filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove within 72 hours after death, the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR A FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death, by the funeral director, and completely filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove within 72 hours after death, the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove within 72 hours after death, the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00939

Item 2 Film 255 1-28-60 et

CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>0958</b> <b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown/ Potomac</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Marylander Nursing Home</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <b>EUGENE LOUIS RUSSELL</b>  |  | 4. DATE OF DEATH <b>January 19, 19 60</b>  |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Feb. 23, 1870</b>                                  |
| 9. AGE (In years last birthday) <b>89</b>  |  | IF UNDER 1 YEAR <b>10</b> Months <b>26</b> Days  | IF UNDER 24 HRS. <b>Hours</b> <b>Min.</b>                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Clerk</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>   | 11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>     |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 13. FATHER'S NAME <b>William R. Russell</b>  |  |
| 14. MOTHER'S NAME <b>Pauline Fleury</b>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>                          |  |
| 16. SOCIAL SECURITY NO. <b>None</b>  |  | 17. INFORMANT <b>Mrs. Harry L. Lowe-10201 Norten Rd.</b> Address <b>Potomac, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>422.1</b> <b>Interossealotic cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>15 yrs</b><br>DUE TO (c) <b>Interval BETWEEN ONSET AND DEATH</b> |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> 19 <b>59</b> to <b>1/19</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>1/19</b> 19 <b>60</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE <b>James P. Kerr</b>  |  | 22b. DATE SIGNED <b>1-19-60</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>  |  | 22d. ADDRESS <b>26618 Ridge Rd., Damascus, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE THEREOF <b>1-21-60</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cem.</b>   | 23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b> ADDRESS   |  | 25a. REC'D BY REGISTRAR <b>JAN 22 '60</b> DATE   | 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thoma</b>                      |

CENTRAL OF DEATH

NOTICE TO THE PUBLIC  
The following is a list of the names of the persons who have been  
identified by the Bureau of the Army Medical Department as having  
been killed in action during the war of 1898-1902.  
The names are given in alphabetical order of the surnames.  
The names of the persons who have been identified as having  
been killed in action during the war of 1898-1902 are given in  
the following list.

1. *[Faint, illegible text]*  
2. *[Faint, illegible text]*  
3. *[Faint, illegible text]*  
4. *[Faint, illegible text]*  
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97. *[Faint, illegible text]*  
98. *[Faint, illegible text]*  
99. *[Faint, illegible text]*  
100. *[Faint, illegible text]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

FOR STATE  
HEALTH DEPT.

Item 18-21 Filed 2/1/60  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

00940

|  |                                  |   |  |   |   |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Montg</u> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>10 yrs</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>56 Silver Spring</u> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>8708 Colesville Rd - apt 203</u>  |                                  |   | d. STREET ADDRESS<br><u>8708 Colesville Rd - apt 203</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br><u>Rose Ruth West</u>   |                                  |   | 4. DATE OF DEATH<br>Month <u>Jan</u> Day <u>31</u> Year <u>1960</u>  |   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>Feb. 13, 1914</u>   |   | 9. AGE (in years last birthday)<br><u>45</u> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>-----</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Wash. D. C.</u>   |   |
| 13. FATHER'S NAME<br><u>Israel West</u>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Cecelia Haas</u>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT<br><u>Attorney S. David Rubenstein-636 Wyatt Bldg. Wash D. C.</u>                             |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Valmid poisoning</u><br><u>970.9</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  |   |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Found dead in bath room of her home. Left suicide note</u> |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Suitland, Maryland</u>         |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                                  |   |  |   |   |
| ACTUAL SIGNATURE<br><u>Frank J. Broschert</u>  |                                  | M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | DATE SIGNED<br><u>Feb 1 1960</u>  |   |
| EXAMINER'S NAME (Type)<br><u>FRANK J. Broschert</u>  |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>  |                                  | 22b. DATE THEREOF<br><u>2/2/60</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Crematory</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey</u>  |                                  | ADDRESS<br><u>Bethesda, Maryland</u>  |  | 24a. REC'D BY REGISTRAR<br><u>DATEB 8 '60</u>   |   |
|  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |   |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0851

CERTIFICATE OF DEATH

00941

Reg. Dist. No.

|   |                                  |   |   |   |   |  |  |
|---|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>   |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>  |                                  |   |   | c. LENGTH OF STAY IN 1b<br><b>11 Years</b>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>6812 Delaware St.</b>  |                                  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HENRY</b> Middle <b>L.</b> Last <b>SCHERR</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>JAN.</b> Day <b>8,</b> Year <b>19 60</b>   |   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 16, 1879</b> | 9. AGE (In years last birthday)<br><b>80</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>22</b> | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Office Equipment</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Chas. Stott &amp; Co.</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D. C.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |
| 13. FATHER'S NAME<br><b>Julius Scherr</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Amelia Sievers</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>Unknown</b>  |   | INFORMANT Address<br><b>Miss Alma B. Scherr-Sister-Item #2</b>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of prostate gland with metastases</b><br>DUE TO (b) <b>177X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.<br>DUE TO (c) <b>11 years</b> |                                  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>11 years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   | 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |   | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   | 21. I certify that I attended the deceased from <b>Aug. 14, 1958</b> to <b>Jan. 9, 1960</b> , that I last saw the deceased alive on <b>Jan. 8, 1960</b> , and that death occurred at <b>8:30</b> M, from the causes and on the date stated above. |   |  |  |
| ACTUAL SIGNATURE<br><b>Alban Eger</b>   |                                  | M.D. <b>1801 Eye St., N. W.</b>   |   | DATE SIGNED   |   |  |  |
| PHYSICIAN'S NAME (Type)<br><b>ALBAN EGER</b>  |                                  | <b>Washington, D. C.</b>  |   |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Bur-Trans.</b>  |                                  | 22b. DATE THEREOF<br><b>1-11-60</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>East Oak Grove</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Morgantown, West Virginia</b>                      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 '60</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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OFFICE OF DEATH

1831

MONROVIA

ARRIVING

MONROVIA

CHURCH OF DEATH

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## 0959 CERTIFICATE OF DEATH

Reg. Dist. No. 215

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Virginia</b> b. COUNTY <b>King George</b> ✓            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>  | c. LENGTH OF STAY IN lb<br><b>8 days</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>King George (Rural, Owens)</b> 83x-3                                 |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital</b>   |  | d. STREET ADDRESS<br><b>Box 238 RR 2</b>  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Martha</b> Middle <b>Chapman</b> Last <b>SHEPARDSON</b>  |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>8</b> Year <b>1960</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Caucasian</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-18-08</b>  |
| 9. AGE (In years last birthday)<br><b>51</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>51</b> Days <b>5</b> Hours <b>1</b> Min.   | IF UNDER 24 HRS.<br>Hours <b>1</b> Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Maine</b>   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 13. FATHER'S NAME<br><b>Ezra Chapman</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Clarke, Unk.</b>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)   |   |
| 16. SOCIAL SECURITY NO.<br><b>no</b>   |  | 17. INFORMANT<br><b>Robert B. Shepardson (H)</b> Address: <b>Box 238 RR 2 King George, Virginia</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal failure</b><br>204.3 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute leukemia</b><br>DUE TO<br>(c) <b>1 month</b>  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>January 1</b> , 19 <b>60</b> , to <b>January 8</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>January 8</b> , 19 <b>60</b> , and that death occurred at <b>11:45 P</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>R.G. Galbraith Jr.</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>R.G. GALBRAITH JR. LT MC USN</b> <b>Bethesda, Maryland</b> |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>1-12-60</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Pauls Church</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Owens Virginia</b>                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Nash &amp; Slaw Funeral Home Ninde, Va.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 12 '60</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>  |

# CERTIFICATE OF DEATH

Home

Virginia

King George

Between (Rural)

8 days

King George (Rural, Queen)

U.S. Naval Hospital

Box 230 RA 2

Martha

Chapman

SHEPARDSON

January 8

Female Caucasian

7-18-08

71

Home

Home

Home

VA

Martha Chapman

Martha, Mrs.

no

Robert E. Shepardson (II) King George, Virginia  
Box 230 RA 2

January 8

January 1

January 8

60

U.S. Naval Hospital

Between, Martha

U.S. GALVESTON J. L. M. D. D.

1-12-08

St. Paul's Church

Queen

Virginia

Head & Shaw Funeral Home, Va.

0960  
CERTIFICATE OF DEATH

Reg. Dist. No. 215

|   |                                      |   |   |   |   |  |  |
|---|--------------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN 1b<br><b>58 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>  |                                      |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Pennsylvania</b><br>b. COUNTY<br><b>Huntingdon</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>75x-3</b><br>d. STREET ADDRESS<br><b>Taylor Highlands</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>Richard</b><br>Middle<br><b>Murray</b><br>Last<br><b>SIMPSON</b>   |                                      |   | 4. DATE OF DEATH<br>Month<br><b>January</b><br>Day<br><b>7</b><br>Year<br><b>19 60</b>                                    |   |   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Caucasian</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-30-00</b>  | 9. AGE (In years last birthday)<br><b>59</b> yrs.   | IF UNDER 1 YEAR<br>Months<br><b>7</b><br>Days<br><b>19</b><br>Hours<br><b>60</b><br>Min.          |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Member of Congress</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- - - - -</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |   |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                      |   | 13. FATHER'S NAME<br><b>Warren B. Simpson</b>   |   |   |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Sue Miller</b>   |                                      |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b><br>16. SOCIAL SECURITY NO.<br><b>WWI</b> |   |   |  |  |
| 17. INFORMANT<br><b>Hospital Records</b>  |                                      |   | Address   |   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>193.0</b> <b>Glioblastoma multiforme, pt. hemiplegia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mos.</b>  |                                      |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                      |   |   |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. _____ p. m. _____<br>19 _____   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) _____ (County) _____ (State) _____  |   |  |  |
| 21. I certify that I attended the deceased from <b>November 10, 1959</b> to <b>January 7, 1960</b> , that I last saw the deceased alive on <b>January 7, 1960</b> , and that death occurred at <b>8:20 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED _____<br>ACTUAL SIGNATURE <b>W. H. Druckemiller</b> M.D. <b>U. S. Naval Hospital</b> <b>1-7-60</b><br>PHYSICIAN'S NAME (Type) <b>W. H. DRUCKEMILLER, CAPT, MC, USN Bethesda 14, Maryland</b> |                                      |   |   |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |                                      | 22b. DATE THEREOF<br><b>1-9-60</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Riverview Cemetery</b>   |   |  |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Huntingdon Pennsylvania</b>   |                                      | 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Jos. Gawler's &amp; Sons Funeral Home Wash., D.C.</b>  |   | 24a. REC'D BY REGISTRAR<br><b>JAN 11 '60</b>  |   |  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kinne</b>  |                                      |   |   |   |   |  |  |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)  
15M 9/58

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

DECEASED (NAME)

AGE

RESIDENCE

U. S. Naval Hospital

Taylor Highlands

Richard

Marion

SYMPTOM

January 7

Male

Caecum

8-30-00

29

Member of Congress

Pennsylvania

James B. Shannon

Bro Miller

Yes

Hospital Records

November 10 29 January 7 00

8:30

January 7

U. S. Naval Hospital

W. H. DRUCKMILLER, CAPT, MC, USN, Detachment 14, Norfolk

Pennsylvania

Hamington

Executive Cemetery

1-9-00

Hamilton

See Chapter 2 & 3 of General Instructions, D.C.



## 0961 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Pennsylvania</b> b. COUNTY                                |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |  |   |  | c. LENGTH OF STAY IN 1b <b>14 days</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 4. DATE OF DEATH<br>First <b>William</b> Middle <b>(None)</b> Last <b>Sivek</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>20</b> Year <b>19 60</b>   |  |   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 8. DATE OF BIRTH <b>March 31, 1916</b>  |  |
| 9. AGE (In years lost birthday) <b>43</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>43</b> Days <b>43</b> Hours <b>43</b> Min. |  | IF UNDER 24 HRS.<br>Months <b>43</b> Days <b>43</b> Hours <b>43</b> Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mills</b>                    |  | 11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13. FATHER'S NAME <b>Karl Sivek</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Mary Mahay</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO. <b>Unascertainable</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |   |  | INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br>204.3 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute leukemia</b> DUE TO<br>(c) |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hours</b><br><b>3 months</b>                         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                      |  |
| 20f. (City or town) (County) (State)   |  |   |  |  |  |   |  |
| 21. I certify that I attended the deceased from <b>January 6, 19 60</b> to <b>January 20, 19 60</b> that I last saw the deceased alive on <b>January 20, 19 60</b> , and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Richard C. Mechanic</b>  |  |   |  | ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>1/21/60</b>  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Richard C. Mechanic, M.D.</b>   |  |   |  | National Institutes of Health<br><b>Bethesda 14, Maryland</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>1/25/60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Grandview Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Monessen, County, Pa.</b>                  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>   |  |   |  | ADDRESS <b>Robert A. Pumphrey, Bethesda, Maryland</b>  |  | 24a. REC'D BY REGISTRAR <b>JAN 22 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b> |  |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF AGRICULTURE

Washington, D.C.

January 20, 1960

Dear Sir:

Re: [illegible]

Enclosed is [illegible]

The Clinical Center, Bethesda, Md., 1500 Research Avenue

William (Hono) [illegible]

January 19, 1960

Enclosed is [illegible]

Enclosed is [illegible]

Very truly yours,

Enclosed is [illegible]

Enclosed is [illegible]

Enclosed is [illegible]

Very truly yours,

January 20, 1960

The Clinical Center

National Institutes of Health  
Bethesda, Md., Maryland

Richard C. Neufeld, M.D.

Enclosed is [illegible]

Robert A. Humphrey, Bethesda, Maryland

## 0962 CERTIFICATE OF DEATH

00945

Reg. Dist. No.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>                |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OLNEY</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>17 DAYS</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>REX</b> Middle <b>--</b> Last <b>SKIPPER</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>9</b> Year <b>19 60</b>  |  |  |  |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8/26/83</b>   |  |
| 9. AGE (In years lost birthday)<br><b>76</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13. FATHER'S NAME<br><b>John Skipper</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Gill</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>220-34-8053</b>  |  |  |  |
| 17. INFORMANT<br><b>HOSPITAL RECORDS</b>   |  |   |  | Address<br><b>OLNEY, MARYLAND</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEPATIC INSUFFICIENCY</b><br><b>581.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>LAENNEC'S CIRRHOSIS OF LIVER</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BILATERAL BRONCHOPNEUMONIA; VOLVULUS OF SIGMOID COLON</b><br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>July</b> , 19 <b>61</b> , to <b>Jan 8</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 8</b> , 19 <b>60</b> , and that death occurred at <b>7:34 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>CLARKSVILLE, MARYLAND</b><br>DATE SIGNED<br><b>1-9-60</b><br>ACTUAL SIGNATURE <b>C. S. Whitaker</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>C. S. WHITAKER, M. D.</b>  |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>1-12-60</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fairview</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Sunnybrook, Baltimore Co. Md</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F.C. Higinbotham, Ellicott City, Md</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hearn</b>                                 |  |

CERTIFICATE OF DEATH

DECEASED: HARRISON, HENRY

DATE OF DEATH: JAN 25/58

PLACE OF DEATH: HOSPITAL

AGE: 72

SEX: M

CAUSE OF DEATH: HEART DISEASE

SIGNATURE: J. H. HARRISON

WITNESSES: J. H. HARRISON, HENRY HARRISON

DEATH CERTIFICATE NO. 1234

DATE OF DEATH: JAN 25/58

PLACE OF DEATH: HOSPITAL

DECEASED: HARRISON, HENRY

DATE OF DEATH: JAN 25/58

AGE: 72

SEX: M

0963

**CERTIFICATE OF DEATH**

00946

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |  |   |  | c. LENGTH OF STAY IN 1b <b>2 days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <b>Dennis</b> Middle <b>Leahy</b> Last <b>Smith</b>  |  |   |  | 4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>1960</b>  |  |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>January 12, 1901</b>                                     |  |
| 9. AGE (In years last birthday) <b>59</b> yrs.   |  | IF UNDER 1 YEAR Months <b>59</b> Days <b>13</b> Hours <b>13</b> Min.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Frozen Custard Stand Oper.</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>            |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 13. FATHER'S NAME <b>James B. Smith</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Johanna Leahy</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> |  |
| 16. SOCIAL SECURITY NO. <b>Unascertainable</b>   |  | 17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral lower lobe pneumonitis - probably viral</b><br>492x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ |  | INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>                               |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Myelogenous Leukemia</b>  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>January 11, 1960</b> , to <b>January 13, 1960</b> that I last saw the deceased alive on <b>January 13, 1960</b> , and that death occurred at <b>8:17PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>1-14-60</b> |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Leon E. Rosenberg</b>  |  | PHYSICIAN'S NAME (Type) <b>Leon E. Rosenberg, M.D.</b> <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>         |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1/18/60</b>   |  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>mt Olivet</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Wash DC</b>                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Huntemann &amp; Son</b>  |  | ADDRESS <b>5732 K St</b>  |  | 24a. REC'D BY REGISTRAR <b>ONE WASH DC</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE

Stapenowille

2 days

Bedford

June 8, 1902

The Clinical Center, Bedford, N. H.

Birth

lastly

female

January 18, 1902

White

Washington, D. C.

Frederic Quincy Stone, M.D., Director

Johnston, N. H.

James B. Smith

Massachusetts The Clinical Center, Bedford, N. H.

Blindfold lower lobe pneumonia - chronic

Bedford, N. H.

60 January 18

January 11

January 13

The Clinical Center  
National Institute of Health  
Bedford, N. H.

January 11, 1902



## 0843 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                       |  |   |
|---|---------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montg</i> MARYLAND  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>DC.</i> b. COUNTY <i>47X-3</i>                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>   |                                       | c. LENGTH OF STAY IN lb <i>6 days</i>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. San &amp; Hosp</i>  |                                       | d. STREET ADDRESS <i>6709 - 2 NW.</i>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Ella</i> Middle <i>Ann</i> Last <i>Smith</i>  |                                       | 4. DATE OF DEATH<br>Month <i>1</i> Day <i>13</i> Year <i>1960</i>  |   |
| 5. SEX <i>F</i>   | 6. COLOR OR RACE <i>W</i>             | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>7/14/78</i>   |
| 9. AGE (In years last birthday) <i>81</i> yrs.  |                                       | 10. IF UNDER 1 YEAR<br>Months <i>8</i> Days <i>13</i> Hours <i>13</i> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>  |                                       | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>   |                                       | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>   |   |
| 13. FATHER'S NAME <i>Edwidge Ward</i>   |                                       | 14. MOTHER'S MAIDEN NAME <i>Rebera</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>  |                                       | 16. SOCIAL SECURITY NO. <i>W.S. H. Record</i>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>200.2 Hypostatic Pneumonia</i><br>DUE TO (b) <i>Malignant Lymphoma - Generalized</i><br>DUE TO (c) <i>Generalized</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                       | INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                       | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <i>19</i> p. m.  |                                       | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                       | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <i>2/17/1943</i> to <i>1/13/1960</i> , that I last saw the deceased alive on <i>1/13/1960</i> , and that death occurred at <i>12 M.</i> from the causes and on the date stated above.   |                                       |  |   |
| ACTUAL SIGNATURE <i>Howard T. Morse</i>   |                                       | DATE SIGNED <i>1/13/60</i>   |   |
| PHYSICIAN'S NAME (Type) <i>Takoma Park</i>  |                                       | ADDRESS (Street, city or town, state) <i>7030 Carroll Ave</i>  |   |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>  | 22b. DATE THEREOF <i>Jan 15, 1960</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cemetery</i>  | 22d. LOCATION (City, town, or county) (State) <i>Arlington Virginia</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters</i>  |                                       | 24. RECEIVED BY REGISTRAR <i>254 Carroll St. N.W.</i>  |   |
| 24a. DATE <i>JAN 14 '60</i>   |                                       | 24b. REGISTRAR'S SIGNATURE <i>Arthur Walters</i>   |   |

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |  |   |  |   |  |
|--|---|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓ |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>  |   |   |  | c. LENGTH OF STAY IN 1b<br><b>Washington, D.C. 47X-3</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Carroll Hall Nursing Home</b>   |   |   |  | d. STREET ADDRESS<br><b>3804 Jennifer Street NW</b>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY</b> Middle <b>JANE</b> Last <b>SMITH</b>  |   |   |  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>16</b> Year <b>1960</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/7/1875</b>                                      | 9. AGE (In years last birthday) yrs. <b>84</b>  | IF UNDER 1 YEAR<br>Month <b>11</b> Day <b>9</b>      | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  |
| 13. FATHER'S NAME<br><b>William Y. Reynolds</b>  |   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Annie E. Wrightson</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | INFORMANT<br><b>J. Reynolds Smith-son-3611 Shepherd St Chevy Chase, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS, GENERAL</b> DUE TO<br>(c) <b></b> |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>SUDDEN</b><br><b>10 YRS</b>                                |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)  | (County)  | (State)  |   |  |
| 21. I certify that I attended the deceased from <b>Nov. 1948</b> to <b>JAN. 16, 1960</b> that I last saw the deceased alive on <b>JAN. 16, 1960</b> , and that death occurred at <b>6:35 P.M.</b> from the causes and on the date stated above.  |   |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Robert G. Angle</b>   |   | ADDRESS (Street, city or town, state)<br><b>5009 Del Ray Ave. Bethesda, Md.</b>   |  |   | DATE SIGNED<br><b>1/16/60</b>                        |   |  |
| PHYSICIAN'S NAME (Type)<br><b>Robert G. Angle</b>  |   | <b>5009 Del Ray Ave. Bethesda, Md.</b>  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>1/20/60</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Geo. Wash. Mem. Cem.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Hyattsville, Md.</b> |   |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>  |   | ADDRESS<br><b>Bethesda, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 20 '60</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Evans</b> |   |  |

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TO HOSPITAL OR A BOARDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used for the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Residence

Location

Carroll Hall Nursing Home

Married - 5.12.19

3000 Leland Avenue, Detroit, Mich.

Wife

John

John

John

Married - 5.12.19

3000 Leland Avenue, Detroit, Mich.

3000 Leland Avenue, Detroit, Mich.

John

John

Married - 5.12.19

3000 Leland Avenue, Detroit, Mich.

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3000 Leland Avenue, Detroit, Mich.

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CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montg</i> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>DC</i> b. COUNTY <i>✓</i>                           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fairland</i>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47X-3   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fairland Nursing Home</i>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) First <i>Miriam</i> Middle <i>Snyder</i> Last <i>Snyder</i>   |  | 4. DATE OF DEATH Month <i>Jan</i> Day <i>12</i> Year <i>1960</i>   |   |
| 5. SEX <i>F</i>   | 6. COLOR OR RACE <i>W</i>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Nov 75</i>                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <i>Latvia</i>  |   |
| 11. BIRTHPLACE (State or foreign country) <i>Latvia</i>   |  | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |   |
| 13. FATHER'S NAME <i>Meyer</i>  |  | 14. MOTHER'S MAIDEN NAME <i>Dora</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>  |  | 16. SOCIAL SECURITY NO. <i>None</i>  |   |
| 17. INFORMANT <i>Ben Snyder</i>   |  | Address <i>932 Ingraham St NW</i>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Ventricular failure</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i><br>(c) <i>3 yrs</i> |  |  | INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i>                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <i>19</i>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                |
| 21. I certify that I attended the deceased from <i>Nov 9</i> , 19 <i>53</i> , to <i>Jan 12</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Jan 12</i> , 19 <i>60</i> , and that death occurred at <i>6 P</i> M, from the causes and on the date stated above.   |  |  |   |
| ACTUAL SIGNATURE <i>Simon C. Weiner</i>   |  | DATE SIGNED <i>Jan 12 1960</i>   |   |
| PHYSICIAN'S NAME (Type) <i>SIMON C. WEINER M.D.</i>   |  | ADDRESS (Street, city or town, state) <i>100 Longfellow St. N.W.</i>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   | 22b. DATE THEREOF <i>1/13-1960</i>   | 22c. NAME OF CEMETERY OR CREMATORY <i>Nat. Memorial Park</i>   | 22d. LOCATION (City, town, or county) (State) <i>Faces Creek Va</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i>   |  | 24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>   |   |
| ADDRESS <i>Washington DC</i>  |  | DATE <i>JAN 15 '60</i>   |   |





## 0965 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>M ontgomery</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>M ontg omery</b>          |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |  |   |  | c. LENGTH OF STAY IN 1b <b>3 Hrs.</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>GEORGE F. STEARNS SR</b>  |  |   |  | 4. DATE OF DEATH <b>1 16 1960</b>  |  |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>12/11/89</b>   |  |
| 9. AGE (In years last birthday) <b>72</b>  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.  |  | 11. IF UNDER 24 HRS. Months Days Hours Min.  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>                                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sales Rep.</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Specialty Advertising Sales Rep.</b>  |  |  |  |
| 13. FATHER'S NAME <b>FREDERICK JOHN STEARNS</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>MARGARET A. McFEELEY</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes Navy</b>   |  |   |  | 16. SOCIAL SECURITY NO. <b>577-16-6403</b>   |  |  |  |
| 17. INFORMANT <b>Wife (Same as Above)</b>  |  |   |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Day</b>   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that I attended the deceased from <b>10 Jan 1960</b> to <b>10 Jan 1960</b> that I last saw the deceased alive on <b>10 Jan 1960</b> , and the death occurred at <b>6:05 PM</b> , from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>William D. And</b>   |  |   |  | ADDRESS (Street, city or town, state) <b>9086 Colaswell Rd Silver Spring, Md</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>William D. And</b>  |  |   |  | DATE SIGNED <b>1/10/60</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 22b. DATE THEREOF <b>1/13/60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>   |  |   |  | ADDRESS <b>SILVER SPRING, MD.</b>  |  | 24a. REC'D BY REGISTRAR <b>JAN 12 '60</b>                                |  |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>  |  |   |  |  |  |  |  |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Brochart Notified

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## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |   |   |   |   |  |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Washington D C</b> b. COUNTY <input checked="" type="checkbox"/> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>28 Days</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D. C.</b> <b>47X-3</b>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Kensington Gardens Sanitarium</b>   |                                  |   |   | d. STREET ADDRESS<br><b>Alban Towers, Wisc. &amp; Mass. Ave., N.W.</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Edmonds</b> Last <b>Stodder</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>27</b> Year <b>1960</b>   |   |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 1, 1875</b> | 9. AGE (In years last birthday)<br><b>84</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Washington D C</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Howard Edmonds</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Owen</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.   |   | INFORMANT   |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>199.2</b> <b>metastatic carcinoma to obstructive jaundice</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.<br>DUE TO (b)<br>DUE TO (c)                         |                                  |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 yrs.</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |   |   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Dec 1959</b> to <b>27 Jan, 1960</b> , that I last saw the deceased alive on <b>26 Jan, 1960</b> , and that death occurred at <b>6 A M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>10511 Summit Ave, Kensington, Md.</b> DATE SIGNED <b>1/27/60</b> |                                  |   |   |   |   |   |  |
| ACTUAL SIGNATURE <b>Horace W. Bernton</b> M.D.   |                                  |   |   | 1/27/60   |   |   |  |
| PHYSICIAN'S NAME (Type) <b>Dr. Horace W. Bernton</b>   |                                  |   |   | <b>10511 Summit Ave, Kensington, Md.</b>  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>CREMATION</b>  |                                  | 22b. DATE THEREOF<br><b>1-27-60</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CREMATORY</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>SUITHAND MARYLAND</b>           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>JOSEPH E. BURCH</b>   |                                  |   |   | ADDRESS<br><b>3034 M St. N.W.</b>   |   | 24a. REG'D BY REGISTRAR<br>DATE <b>JAN 29 '60</b>                                   |  |
|  |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>  |   |   |  |

1 **X**

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
WASHINGTON, D. C.

Washington, D. C.

28 Days

Washington, D. C.

Edwards

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## CERTIFICATE OF DEATH

00952

Reg. Dist. No.

0958

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>STATE <u>MD</u> b. COUNTY <u>Prince George</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt 1 Silver Spring</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville 1663-2</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bradford Nursing Home</u>   |   | d. STREET ADDRESS <u>5303 46th Ave</u>   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |   |
| 3. NAME OF DECEASED (Type or print) <u>Hester</u> First <u>Stubbs</u> Middle <u>Stubbs</u> Last   |   | 4. DATE OF DEATH <u>Jan</u> Month <u>2</u> Day <u>19</u> Year <u>60</u>  |   |
| 5. SEX <u>female</u>  | 6. COLOR OR RACE <u>C</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 1 1897</u>                |
| 9. AGE (In years last birthday) <u>62</u> yrs.  |   | IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Bladensburg Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>Pinco E. Stubbs</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Love</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT <u>Mrs Leticia Powell</u> Address <u>1872 Beving Rd Washington D.C.</u>   |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u><br>DUE TO <u>Hemiplegia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis (S.T.S. Doubtful)</u><br>DUE TO (c) |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)              |
| 21. I certify that I attended the deceased from <u>Dec 31, 1959</u> to <u>Jan 2, 1960</u> , that I last saw the deceased alive on <u>Jan 1, 1960</u> , and that death occurred at <u>1:55 P.M.</u> from the causes and on the date stated above.  |   |  |   |
| ACTUAL SIGNATURE <u>Webster Sewell</u> M.D.   |   | ADDRESS (Street, city or town, state) <u>Rt 1 Silver Spring Md.</u> DATE SIGNED <u>1-2-60</u>  |   |
| PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF   | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State)     |
| <u>Burial</u>   | <u>1/5/60</u>   | <u>Woodlawn Cem. Washington D.C.</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Gardner</u> ADDRESS <u>Rockville Md.</u>  |   | 24a. REC'D BY REGISTRAR DATE <u>JAN 8 '60</u>  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> |

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





0967

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>WASHINGTON</b> b. COUNTY <b>84x-3</b> ✓                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BETHESDA (Rural)</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>VASHON IS. <del>SEATTLE</del> near Seattle</b>                       |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. NAVAL HOSPITAL BETHESDA, MD</b>  |                                  | d. STREET ADDRESS<br><b>BOX 53</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SWAN</b> Middle <b>(N)</b> Last <b>SWANSON</b>   |                                  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>1</b> Year <b>1960</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-5-83</b>                        |
| 9. AGE (In years last birthday)<br><b>76</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min.                           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Butcher</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SWEDEN</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>U.S.</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                                  |   |  |
| 13. FATHER'S NAME<br><b>ANDREW SWANSON</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>HELDIA C. OLSEN</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b><br><b>(S) Frank SWANSON 878 North Ohio St. Arlington Va.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>785.6 Malnutrition</b><br>DUE TO (b) <b>Chronic Diarrhea, cause unknown</b><br>DUE TO (c) <b>1 year</b>                    |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>20 OCTOBER</b> , 1959, to <b>1 JANUARY</b> , 1960, that I last saw the deceased alive on <b>1 JANUARY</b> , 1960 and that death occurred at <b>2:55 P. M.</b> from the causes and on the date stated above. |                                  |   |  |
| ACTUAL SIGNATURE<br><b>Joseph E. Stichter</b>  |                                  | ADDRESS (Street, city or town, state)<br><b>U.S. Naval Hospital, Bethesda, Md. 1-2-60</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>JOSEPH E. STITCHER LT MC USN</b>   |                                  | U.S. Naval Hospital, Bethesda, Md.  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>1-7-60</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Washelle Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Seattle, Washington</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R. Robert E. Humphrey</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE JAN 4 '60</b>  |  |
| ADDRESS<br><b>557 Wisconsin Ave. Bethesda, Md.</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>  |  |

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR A FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0968

## CERTIFICATE OF DEATH

Reg. Dist. No.

00954

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Mar Park</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Seven Years</b>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Mar Park</b>   |                                  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>5710 Namakagen Road</b>   |                                  | d. STREET ADDRESS<br><b>5710 Namakagen</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CATHERINE</b> Middle <b>MARY</b> Last <b>SWEENEY</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Jan</b> Day <b>20</b> Year <b>1960</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 29, 1871</b> |
| 9. AGE (In years last birthday)<br><b>88 yrs</b>   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Ireland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>John Long</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Byrnes</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>Josephine C. Sweeney #1d Daughter</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br><b>586x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>obstruction of common bile duct &amp; jaundice</b> DUE TO<br>(c) <b>multiple stones.</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs.</b><br><b>2 days.</b> |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Cardio vascular decompensation &amp; generalized arteriosclerosis.</b>   |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Jan 1, 1949</b> , to <b>Jan 20, 1960</b> , that I last saw the deceased alive on <b>1/20/60</b> , 19 <b>60</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>4301 48th St. N.W., Wash DC 1/20/60</b>   |                                  |   |  |
| ACTUAL SIGNATURE<br><b>S. A. THOMAS, M.D.</b>  |                                  | M.D. <b>4301-48th St., N.W.</b>   |  |
| PHYSICIAN'S NAME (Type)  |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>1-23-1960</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D.C.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Jan Long, Jr.</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 22 '60</b>   |  |
| ADDRESS<br><b>317 Penna. Ave., SE DC3</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Carlton S. Knaus</b>   |  |



## CERTIFICATE OF DEATH

Reg. Dist. No.

00955

0969

|  |  |                                  |  |  |  |  |  |
|--|--|----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>  |  |                                  |  | c. LENGTH OF STAY IN 1b <b>Box 167</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 167</b>  |  |                                  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Edward</b> Middle <b>Robert</b> Last <b>Taylor</b>   |  |                                  |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>27</b> Year <b>1960</b>  |  |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>C</b>        |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>5/8/ 1887</b>                                      |  |
|  |  |                                  |  | 9. AGE (In years lost, birthday) <b>72</b> yrs.  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.                             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardener</b>  |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>              |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |                                  |  |  |  |  |  |
| 13. FATHER'S NAME <b>William Robert Taylor</b>   |  |                                  |  | 14. MOTHER'S MAIDEN NAME <b>Catherine NMN Williams</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  |                                  |  | 16. SOCIAL SECURITY NO.  |  | INFORMANT <b>Lottie Taylor</b> Address <b>Olney, Md.</b>               |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate, Metastatic</b><br>DUE TO (b) <b>Carcinoma of Prostate</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>5yrs</b> |  |                                  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |  |                                  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
|  |  |                                  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <b>1/26</b> to <b>1/27</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/26</b> , 19 <b>60</b> , and that death occurred at <b>10:20 P.M.</b> from the causes and on the date stated above.  |  |                                  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>C. H. L. GON</b>   |  |                                  |  | ADDRESS (Street, city or town, state) <b>Sandy Spring Md.</b> DATE SIGNED <b>1/27/60</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>C. H. L. GON</b>  |  |                                  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>1/30/60</b> |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Sandy Spring.</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Smothers</b> ADDRESS <b>Rockville, Md.</b>   |  |                                  |  | 24a. REC'D BY REGISTRAR <b>FEB 1 60</b> DATE   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>                      |  |

1  
X  
X  
1  
0

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

Married

Married

Married

Olney

Olney

Box 107

Box 107

January

1917

Robert

Edward

Male

73

Married

Married

Catherine M. Williams

William Robert Taylor

Olney, Mo.

Olney, Mo.

*Handwritten signature*

1917

*Handwritten signature*

C. H. L. 1917

1917

1917

1917

1917

1917



## CERTIFICATE OF DEATH

Reg. Dist. No.

0970

|   |                                    |  |  |
|---|------------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>District of Columbia</b> b. COUNTY                        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                    | c. LENGTH OF STAY IN 1b<br><b>3 days</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |                                    | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b> 47X-3  |  |
| d. STREET ADDRESS<br><b>2475 Virginia Avenue, N.W.</b>  |                                    | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Jean</b> Middle <b>(None)</b> Last <b>Thurmond</b>  |                                    | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>6</b> Year <b>1960</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>14 July 1926</b>        |
| 9. AGE (In years lost birthday)<br><b>33</b> yrs.   |                                    | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  | 11. IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>South Carolina</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Horace Crouch</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Inez Breazeale</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                    | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>250-44-4480</b>   |  |
| 17. INFORMANT<br><b>The Medical Record</b>  |                                    | Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.<br>(b) <b>Increased Intracranial Pressure</b><br>DUE TO<br>(c) <b>Brain Tumor, rt. hemisphere</b> |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><b>16 hrs.</b><br><b>2 weeks</b><br><b>4 mos.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                    | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                    | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                    | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>January 3</b> , 19 <b>60</b> , to <b>January 6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>January 6</b> , 19 <b>60</b> , and that death occurred at <b>8:35 A.M.</b> , from the causes and on the date stated above.  |                                    |  |  |
| ACTUAL SIGNATURE <b>E. J. Laskowski M.D.</b>  |                                    | ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>1-6-60</b>   |  |
| PHYSICIAN'S NAME (Type) <b>E. J. Laskowski, M.D.</b>  |                                    | <b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 22b. DATE THEREOF<br><b>1-6-60</b> | 22c. NAME OF CEMETERY OR CREMATORY   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Guy H. Gaudin</b>  |                                    | ADDRESS<br><b>1756 Park N.W. D.C.</b>  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 8 '60</b>  |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thoma</b>   |  |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6931

District of Columbia

Montgomery

Washington

3 days

Witness

5125 Virginia Avenue, N.W.

The Clinical Center, Bethesda, Md.

Thurmond

(Name)

John

11 July 1986

Female

U.S.A.

South Carolina

Home

Montgomery

Inter Urnatio

Veracoe Branch

24-1-1-1-1-1-1 The Clinical Center, Bethesda, Md.

10 mos.

Cardiopulmonary System

2 weeks

Increased Interstitial Pressure

1 mos.

Brain Tumor, rt. hemisphere

January 3 - 30 January 6 - 30

1986

January 6 - 30

1-0-00

The Clinical Center  
National Institute of Health  
Bethesda, Md., Maryland

J. A. Thompson, M.D.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00957

Reg. Dist. No.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u><br>c. LENGTH OF STAY IN lb <u>21 yrs</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3905 Smd Rd</u>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>mnty</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u><br>d. STREET ADDRESS <u>3905 Smd Rd</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Harold</u> Middle <u>William</u> Last <u>Tipton, Jr</u><br><b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>2</u> Year <u>1960</u>  |  |   |  | <b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u><br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Sept 4-1902</u><br><b>9. AGE</b> (In years last birthday) <u>57</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>                    |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Coal Engineer</u><br><b>13. FATHER'S NAME</b> <u>Isaac Tipton</u>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Gov't</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>   |  | <b>11. BIRTHPLACE</b> (State or foreign country) <u>Conn.</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>   |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>No</u><br><b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>  |  | <b>17. INFORMANT</b> <u>Harold W. Tipton Jr.</u> Address <u>7902 15th - apt 102 Hyattsville md</u>  |  |  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO (b) <u>420.1</u><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>  </u><br>DUE TO (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u><br>INTERVAL BETWEEN ONSET AND DEATH <u>  </u> |  |   |  |  |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  |  | <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)   |  |  |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>   |  |   |  |  |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>Frank J. Brosehart</u> <b>M.D.</b><br><b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSEHART</u><br><b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>1-5-60</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln Cem.</u> <b>22d. LOCATION (City, town, or county)</b> <u>Prince George Co., Md.</u>  |  |   |  | <b>DATE SIGNED</b><br><b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>Jan 2-1960</u>   |  |  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY, Bethesda, Md.</u> <b>ADDRESS</b>   |  |   |  | <b>24a. REC'D BY REGISTRAR</b> <u>  </u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u><br><b>DATE</b> <u>JAN 5 '60</u>  |  |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARTIN STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                               |  |                                |  |                                   |  |
|-------------------------------|--|--------------------------------|--|-----------------------------------|--|
| NAME OF DECEASED<br>_____     |  | SEX<br>_____                   |  | AGE<br>_____                      |  |
| RACE<br>_____                 |  | OCCUPATION<br>_____            |  | PLACE OF BIRTH<br>_____           |  |
| DATE OF DEATH<br>_____        |  | TIME OF DEATH<br>_____         |  | PLACE OF DEATH<br>_____           |  |
| CAUSE OF DEATH<br>_____       |  | MANNER OF DEATH<br>_____       |  | SIGNATURE OF EXAMINER<br>_____    |  |
| MEDICAL HISTORY<br>_____      |  | PHYSICAL EXAMINATION<br>_____  |  | LABORATORY TESTS<br>_____         |  |
| SOCIAL HISTORY<br>_____       |  | PATHOLOGICAL FINDINGS<br>_____ |  | OTHER INFORMATION<br>_____        |  |
| SIGNATURE OF WITNESS<br>_____ |  | SIGNATURE OF DECEASED<br>_____ |  | SIGNATURE OF NEXT OF KIN<br>_____ |  |
| SIGNATURE OF CLERK<br>_____   |  | SIGNATURE OF JURY<br>_____     |  | SIGNATURE OF JUDGE<br>_____       |  |

This certificate is to be filled out by the medical examiner who examines the body of the deceased. It is to be filed in the office of the State Department of Health, Baltimore, Maryland.

18 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0971 CERTIFICATE OF DEATH

Reg. Dist. No. 215

00958

|  |                                  |   |                                     |  |   |   |   |
|--|----------------------------------|---|-------------------------------------|--|---|---|---|
| 1. PLACE OF DEATH<br>COUNTY <b>Montgomery</b> MARYLAND   |                                  |   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>✓</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>50 days</b>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Arlington</b> 83x-3                           |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, Bethesda, Md.</b>  |                                  |   |                                     | d. STREET ADDRESS<br><b>1518 N. 12th St.</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Monte</b> Middle <b>Audel</b> Last <b>TRIPLETT</b>   |                                  |   |                                     | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>30</b> Year <b>1960</b>  |   |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Cauc.</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-10-12</b> |  | 9. AGE (In years lost birthday)<br><b>47</b> yrs. | IF UNDER 1 YEAR<br>Months <b>47</b> Days <b>0</b> Hours <b>0</b> Min.                             | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret. U.S. Navy</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- - - - -</b>   |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Oklahoma</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Walter Triplett</b>  |                                  |   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Maud Mahurin</b>  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Yes WWII, Korean</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>025-28-9429</b>   |                                     | INFORMANT Address<br><b>Mary Triplett, 1518 N. 12th St., Arl., Va.</b>   |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cirrhosis, Liver, Lannec's</b><br>581.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH |                                  |   |                                     |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>January 30, 1960</b> to <b>January 30, 1960</b> , that I last saw the deceased alive on <b>30 January 1960</b> , and that death occurred at <b>1545 M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>1/31/60</b>  |                                  |   |                                     |  |   |   |   |
| ACTUAL SIGNATURE<br><b>R. C. THOMAS</b>  |                                  | PHYSICIAN'S NAME (Type) <b>R. C. THOMAS</b> LT MC USN Bethesda, Md.   |                                     |  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>2-3-60</b>  |                                     | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b>                        |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Arlington Funeral Home, 3901 N. Fairfax Dr.</b>   |                                  |   |                                     | 24a. REC'D BY REGISTRAR<br>DATE <b>FEB 2 '60</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>   |   |

18 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Virginia

Arlington

50 days

1210 N. 12th St.

U.S. Naval Hospital, Bethesda, Md.

THIRTY

Angel

None

12-10-12

Cause

Male

Oklahoma

Reg. U.S. Navy

Handwritten

Warrior Project

Mary Elizabeth, 1210 N. 12th St., Arlington, Va.

025-60-4023

Cincinnati, Ohio, 1210 N. 12th St.

60 - January 30 - 60

January 30

U.S. Naval Hospital

1210 N. 12th St., Arlington, Va.

H. C. KENNEDY

Virginia

Arlington

Arlington Memorial

025-60-4023

Female

1210 N. 12th St., 3001 N. 12th St., Arlington, Va.



0872

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                     |   |  |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery Co.</u> MARYLAND   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>MO.</u>                           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockington</u>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>584700 Bradley Blvd. Chevy Chase</u>                                 |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Kensington Gardens San.</u>  |                                     | d. STREET ADDRESS<br><u>3000 McCamas Ave.</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Louis</u> Middle <u>J.</u> Last <u>Tunis</u>  |                                     | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>19</u> Year <u>1960</u>   |  |
| 5. SEX<br><u>m</u>  | 6. COLOR OR RACE<br><u>W</u>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 25, 1895</u>                                 |
| 9. AGE (In years lost birthday)<br><u>64</u> yrs.   |                                     | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Architect</u>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>PENNA.</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>PENNA.</u>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |  |
| 13. FATHER'S NAME<br><u>Phillip Tunis</u>   |                                     | 14. MOTHER'S MAIDEN NAME<br><u>Wm. known</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>   |                                     | 16. SOCIAL SECURITY NO.<br><u>UNKNOWN</u>   |  |
| 17. INFORMANT<br><u>Richard L. Tunis</u>  |                                     | Address<br><u>1963 Rosemary Hills Dr. S.S. 40</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u><br><u>492x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Cerebral Arteriosclerosis</u> |                                     |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u>                        |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>1957</u> , 19 <u>  </u> to <u>1/19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>60</u> , and that death occurred at <u>6:55 AM</u> , from the causes and on the date stated above.   |                                     |   |  |
| ACTUAL SIGNATURE<br><u>Irving W. Winik</u>  |                                     | ADDRESS (Street, city or town, state)<br><u>M.D. 3900 McKinley St. N.W. Washington, D.C.</u>  |  |
| PHYSICIAN'S NAME (Type)<br><u>Irving W. Winik</u>   |                                     | DATE SIGNED<br><u>1/19/60</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>1 21-60</u>   | 22b. DATE THEREOF<br><u>1 21-60</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>ROOSEVELT CEM.</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>BUCKS CO. PENNA.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Edward M. Smith</u>  |                                     | 24a. REC'D BY REGISTRAR<br><u>JAN 20 '60</u>  |  |
| ADDRESS<br><u>4217 94th NW DC</u>   |                                     | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur E. ...</u>  |  |

1

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. This certificate may be filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

0832  
CERTIFICATE OF DEATH

0832

0832

0832

0832

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G255 1/27/60 iwk

00360

Reg. Dist. No.

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>0972</b> <b>MARYLAND</b>  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> <b>47X-3</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Wheaton</b> <b>DOA</b>   |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b> <b>47X-3</b>                                     |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Colesville-Glenmont Road</b>   |  |  | d. STREET ADDRESS<br><b>808 Hilltop Ter. S.E.</b>  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Melvin</b> Middle <b>Carl</b> Last <b>Turner</b>  |  |  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>15,</b> Year <b>1960 19</b>   |   |   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>ool.</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                          | 8. DATE OF BIRTH<br><b>2/26/33</b>   | 9. AGE (In years last birthday)<br><b>26</b> yrs.               | IF UNDER 1 YEAR<br>Months Days Hours Min.                           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>laborer</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Wash. D. C.</b> |   |
| 13. FATHER'S NAME<br><b>William A. Turner</b>   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Viola S. Cousins</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>William A. Turner, Madison, Va.</b>         |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxia</b><br><b>823X</b><br>DUE TO <b>drowning</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>drowning</b><br>(c) <b>drowning</b><br>DUE TO <b>drowning</b><br>(c) <b>drowning</b>   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Apparently lost control of a Front End Loader. Struck tree and upset in creek</b> |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>3:14 p.m. 1/15/60</b>   | 20d. INJURY OCCURRED<br>While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>road</b>  | 20f. (City or town)<br><b>Wheaton</b>  | (County)<br><b>Montg.</b>                                       | (State)<br><b>Md.</b>   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |  |  |   |   |
| ACTUAL SIGNATURE <b>Frank J. Broschart</b>  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   |
| EXAMINER'S NAME (Type)<br><b>Frank J. Broschart</b>   |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |   |
|   |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Type)<br><b>Removal</b>  |  |  | 22b. DATE THEREOF<br><b>1/16/60</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Frazier Funeral Home.,</b> |
|   |  |  | 22d. LOCATION (City, town, or county)<br><b>Washington, D. C.</b>  |   | (State)<br><b>D. C.</b>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert L. Surwood</b>  |  |  | ADDRESS<br><b>Rockville, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br><b>JAN 19 '60</b>                        |
|   |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Frank</b>   |   |   |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00961

Reg. Dist. No.

|  |   |  |  |
|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> MARYLAND   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Washington Sanatorium &amp; Hosp.</b>   |   | d. STREET ADDRESS<br><b>320 Quackenbos St. N.E.</b>  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>Sarah</b> Middle <b>Ann</b> Last <b>Turner</b>  |   | <b>4. DATE OF DEATH</b><br>Month <b>Jan.</b> Day <b>16,</b> Year <b>1960</b>   |  |
| <b>5. SEX</b><br><b>female</b>   | <b>6. COLOR OR RACE</b><br><b>white</b> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><b>11/30/1862</b> |
| <b>9. AGE</b> (In years last birthday)<br><b>97</b> yrs.   |   | <b>IF UNDER 1 YEAR</b><br>Months <b>0</b> Days <b>0</b>  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>France</b>  |  |
| <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>France</b>  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b>  |  |
| <b>13. FATHER'S NAME</b><br><b>Paul Cardon</b>   |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Suzanne Gouding</b>  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>—</b>  |   | <b>16. SOCIAL SECURITY NO.</b><br><b>—</b>   |  |
| <b>17. INFORMANT</b><br><b>Hosp. Record</b>  |   | <b>Address</b><br><b>320 Quackenbos St. N.E.</b>   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Aspiration of mucus and stomach contents</b><br>(c) <b>postop 11 days following repair of rt. hip fracture</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>—</b> |   |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input checked="" type="checkbox"/> <b>CAUSE OF DEATH.</b><br><b>Repaired fall on floor at home</b>   |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>Repaired fall on floor at home</b>                       |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <b>1</b> o. m. <b>3</b> p. m. <b>1-3-1960</b>  |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>   |   | <b>20f. (City or town)</b><br><b>Washington D.C.</b>   |  |
| <b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>                                   |   |  |  |
| <b>ACTUAL SIGNATURE</b> <b>Frank J. Broschart</b> M.D.   |   | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>   |  |
| <b>EXAMINER'S NAME (Type)</b> <b>Frank J. Broschart</b>  |   | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>   |  |
| <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>  |   | <b>DATE SIGNED</b><br><b>Jan. 16, 1960</b>   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>  |   | <b>22b. DATE THEREOF</b><br><b>1-20-60</b>   |  |
| <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Cedar Hill</b>   |   | <b>22d. LOCATION (City, town, or county)</b><br><b>Southland Md.</b>   |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Wesley Howard</b>  |   | <b>24a. REC'D BY REGISTRAR</b><br><b>DATE JAN 22 '60</b>   |  |
| <b>ADDRESS</b><br><b>4812 9th Ave.</b>   |   | <b>24b. REGISTRAR'S SIGNATURE</b><br><b>Ch. L. S. K. R.</b>  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

SPARKS



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00962

0845

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                       |   |   |   |  |
|--|---------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                       |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |                                       |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>  |   |  |
| c. LENGTH OF STAY IN 1b <u>5 years</u>   |                                       |   | d. STREET ADDRESS <u>101 Grant Avenue</u>   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 Grant Avenue</u>   |                                       |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 3. NAME OF DECEASED (Type or print) <u>ANNAE VIRGINIA VEATCH</u>   |                                       |   | 4. DATE OF DEATH <u>January 18 1960</u>   |   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>         | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH <u>3-30-1876</u>   | 9. AGE (In years last birthday) <u>83</u> yrs.              | IF UNDER 1 YEAR IF UNDER 24 HRS.                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>   |                                       | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>  | 11. BIRTHPLACE (State or foreign country) <u>Bayard, West. Va.</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>            |
| 13. FATHER'S NAME <u>Wenzel</u>  |                                       |   | 14. MOTHER'S MAIDEN NAME <u>Not Available</u>   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                                       | 16. SOCIAL SECURITY NO. <u>_____</u>  | 17. INFORMANT <u>James W. Gray (Same as item #2)</u>  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br><u>332x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis</u><br>DUE TO (c) _____ |                                       |   |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                                       |   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                       |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                                       | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)               |
| 21. I certify that I attended the deceased from <u>Jan 16, 1960</u> to <u>Jan 18, 1960</u> , that I last saw the deceased alive on <u>Jan 17, 1960</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.   |                                       |   |   |   |  |
| ACTUAL SIGNATURE <u>A. B. Little</u>   |                                       | ADDRESS (Street, city or town, state) <u>6911 5th St NW DC</u> DATE SIGNED <u>1/18/60</u>   |   |   |  |
| PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, MD</u>  |                                       |   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>Jan 21, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>   | 22d. LOCATION (City, town, or county) <u>Washington</u>   | (State) <u>D.C.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>  |                                       | ADDRESS <u>254 Carroll St NW DC</u>   |   | 24a. REC'D BY REGISTRAR <u>_____</u> DATE <u>JAN 21 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Walter S. Turner</u> |

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEATH

1920

|  |  |  |  |
|--|--|--|--|
| <p>NAME OF DECEASED<br/><i>John Doe</i></p>        |  | <p>AGE<br/><i>45</i></p>                                 |  |
| <p>SEX<br/><i>Male</i></p>                         |  | <p>RACE<br/><i>White</i></p>                             |  |
| <p>DATE OF BIRTH<br/><i>Jan 15 1875</i></p>        |  | <p>PLACE OF BIRTH<br/><i>St. Louis, Mo.</i></p>          |  |
| <p>DATE OF DEATH<br/><i>Dec 10 1920</i></p>        |  | <p>PLACE OF DEATH<br/><i>Home</i></p>                    |  |
| <p>CAUSE OF DEATH<br/><i>Heart Disease</i></p>     |  | <p>IMMEDIATE CAUSE<br/><i>Myocardial Infarction</i></p>  |  |
| <p>PERMANENT CAUSE<br/><i>Arteriosclerosis</i></p> |  | <p>INTERMEDIATE CAUSE<br/><i>Coronary Thrombosis</i></p> |  |
| <p>PRE-EXISTING DISEASES<br/><i>None</i></p>       |  | <p>PRE-EXISTING CONDITIONS<br/><i>None</i></p>           |  |
| <p>DATE OF EXAMINATION<br/><i>Dec 12 1920</i></p>  |  | <p>PLACE OF EXAMINATION<br/><i>Home</i></p>              |  |
| <p>SIGNATURE OF PHYSICIAN<br/><i>John Doe</i></p>  |  | <p>SIGNATURE OF REGISTRAR<br/><i>John Doe</i></p>        |  |
| <p>DATE OF REGISTRATION<br/><i>Dec 15 1920</i></p> |  | <p>PLACE OF REGISTRATION<br/><i>Home</i></p>             |  |

## CERTIFICATE OF DEATH

Reg. Dist. No.

00963

0846

|   |                               |  |   |   |  |
|---|-------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>47x-3</u><br>b. COUNTY <u>District of Columbia</u> |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |                               |  | c. LENGTH OF STAY IN 1b <u>10 hours</u>   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San and Hospital</u>   |                               |  | d. STREET ADDRESS <u>3831 Porter St</u>   |   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Xvonne</u> Middle <u>—</u> Last <u>Verhine</u>  |                               |  | 4. DATE OF DEATH<br>Month <u>Jan</u> Day <u>7</u> Year <u>1960</u>  |   |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-25-1906</u>  |   | 9. AGE (In years last birthday) <u>53</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office worker</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>  |   | 11. BIRTHPLACE (State or foreign country) <u>Illinois</u> |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |                               |  |   |   |  |
| 13. FATHER'S NAME <u>Nelson Verlaine</u>  |                               |  | 14. MOTHER'S MAIDEN NAME <u>Rosa Walker</u>   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                               |  | 16. SOCIAL SECURITY NO. <u>Hospital Records</u>   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>—</u><br>DUE TO (c) <u>—</u> |                               |  | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>  |                               |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                               |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>                         |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               |  | 20f. (City or town) (County) (State)  |   |  |
| 21. I certify that I attended the deceased from <u>July 1956</u> to <u>Jan 7, 1960</u> , that I last saw the deceased alive on <u>Jan 7, 1960</u> and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above.   |                               |  |   |   |  |
| ACTUAL SIGNATURE <u>Robert A Hare</u>   |                               |  | ADDRESS (Street, city or town, state) <u>7600 Takoma Park, Md</u>   |   |  |
| PHYSICIAN'S NAME (Type) <u>Robert A Hare</u>  |                               |  | DATE SIGNED <u>1/7/60</u>   |   |  |
| 22a. BURIAL (CREMATION) REMOVAL (Specify) <u>1-11-60</u>  |                               | 22b. DATE THEREOF  |   | 22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>      |  |
| 22d. LOCATION (City, town, or county) <u>SUITLAND MD.</u>   |                               | (State)  |   |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. Hawley's Sons Inc.</u>   |                               |  | ADDRESS <u>1756 P. Ave. N.W.</u>  |   |  |
| 24a. REC'D BY REGISTRAR <u>Jan 12 '60</u>   |                               |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>   |   |  |

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

0000



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0972

CERTIFICATE OF DEATH

Reg. Dist. No.

00964

|   |                                  |   |  |   |  |  |  |
|---|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>168 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>West Virginia</b><br>b. COUNTY<br><b>85 x -3</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Martinsburg</b><br>d. STREET ADDRESS<br><b>Route #1</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>John</b><br>Middle<br><b>Upton</b><br>Last<br><b>Walker</b>  |                                  | 4. DATE OF DEATH<br>Month<br><b>January</b><br>Day<br><b>12</b><br>Year<br><b>1960</b>  |  |   |  |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 4, 1912</b>           | 9. AGE (In years last birthday)<br><b>47</b> yrs.   | IF UNDER 1 YEAR<br>Months<br>Days<br>Hours<br>Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>   |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Upton Walker</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Susie Haufman</b> |   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>232-26-7771</b>   |  | INFORMANT<br><b>The Medical Record</b><br>Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br><b>163X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer of the lung</b> DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>8 months</b>   |                                  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <b>July 28</b> , 19 <b>59</b> , to <b>January 12</b> , 19 <b>60</b> that I last saw the deceased alive on <b>January 12</b> , 19 <b>60</b> , and that death occurred at <b>10:45A</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>The Clinical Center 1-13-60</b><br>NATIONAL INSTITUTES OF HEALTH<br><b>Bethesda 14, Maryland</b> |                                  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Charles E. Mengel</b> M.D.   |                                  | PHYSICIAN'S NAME (Type)<br><b>CHARLES E. MENGEL, M. D.</b>  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>1/15/60</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Edge Hill Cemetery</b>   |  |  |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Charlestown, W. Va.</b>   |                                  |   |  |   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>   |                                  | ADDRESS<br><b>Bethesda, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br><b>JAN 15 '60</b>  |  |  |  |
|   |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

Montgomery

Latitudes

The Clinical Center, Bethesda II, Md.

John

Melo

Patner

Walter

Yes

Secondary

Center of the Line

1975

1975

January 12

The Clinical Center

National Institutes of Health

Bethesda II, Maryland

Robert A. Thompson



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00965

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|  |                                 |   |   |   |   |
|--|---------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>0974</b> <b>MARYLAND</b>   |                                 |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/><br>a. STATE <b>Maryland</b> b. COUNTY <b>Xenox Howard</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b>   |                                 | c. LENGTH OF STAY IN 1b<br><b>DOA</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sandy Springs Woodbine 13X-2</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Montgomery County Gen. Hosp.</b>  |                                 |   | d. STREET ADDRESS<br><b>RED # 1</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Remus</b> Middle <b>A.</b> Last <b>Walker</b>  |                                 |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>22,</b> Year <b>1960</b> <b>19</b>   |   |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>ool.</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/2/1910</b>   |   | 9. AGE (In years last birthday)<br><b>49</b> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>laborer</b>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |
| 13. FATHER'S NAME<br><b>Remus Walker</b>   |                                 |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizebeth Awkward</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>(If yes, give war or dates of service)</b>  |                                 | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Cordelia Walker</b> Address <b>Woodbine, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage &amp; laceration</b><br><b>825X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>crushed skull</b><br>DUE TO<br>(c) <b>Multiple injuries, extreme</b>   |                                 |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                 |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Passenger in auto involved in accident</b>               |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>8:00 p. m. 19</b>  |                                 | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Md. R - 108</b>  |   | 20f. (City or town) (County) (State)<br><b>nr Olney Montg. Md.</b>                                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                 |   |   |   |   |
| ACTUAL SIGNATURE<br><i>Frank J. Broschart</i>  |                                 | EXAMINER'S NAME (Type)<br><b>Frank J. Broschart</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED<br><b>Jan. 26, 1960</b> |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                 | 22b. DATE THEREOF<br><b>1/27/60</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ash Memorial.,</b>   |   |
| 22d. LOCATION (City, town, or county) (State)<br><b>Sandy Spring, Md.</b>  |                                 | 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Robert L. Snowden</i>  |   | ADDRESS<br><b>Rockville, Md.</b>  |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 28 '60</b>  |                                 | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Hanes</i>  |   |   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br><u>JOHN J. SMITH</u>     |  | 2. SEX<br><u>Male</u>                  |  |
| 3. AGE<br><u>45</u>                             |  | 4. RACE<br><u>White</u>                |  |
| 5. DATE OF DEATH<br><u>Jan. 15, 1933</u>        |  | 6. TIME OF DEATH<br><u>10:30 AM</u>    |  |
| 7. PLACE OF DEATH<br><u>Home</u>                |  | 8. STREET<br><u>1234 Main St.</u>      |  |
| 9. CITY<br><u>Baltimore</u>                     |  | 10. COUNTY<br><u>City of Baltimore</u> |  |
| 11. STATE<br><u>Md.</u>                         |  | 12. ZIP CODE<br><u>21201</u>           |  |
| 13. OCCUPATION<br><u>Engineer</u>               |  |  |  |
| 14. MARITAL STATUS<br><u>Married</u>            |  |  |  |
| 15. NAME OF SPOUSE<br><u>John J. Smith</u>      |  |  |  |
| 16. NAME OF NEXT OF KIN<br><u>John J. Smith</u> |  |  |  |
| 17. NAME OF PHYSICIAN<br><u>Dr. J. H. Jones</u> |  |  |  |
| 18. NAME OF HOSPITAL<br><u>None</u>             |  |  |  |
| 19. NAME OF BURIAL PLACE<br><u>None</u>         |  |  |  |
| 20. NAME OF FUNERAL HOME<br><u>None</u>         |  |  |  |
| 21. NAME OF CEMETERY<br><u>None</u>             |  |  |  |
| 22. NAME OF INTERMENT<br><u>None</u>            |  |  |  |
| 23. NAME OF CREMATOR<br><u>None</u>             |  |  |  |
| 24. NAME OF URN<br><u>None</u>                  |  |  |  |
| 25. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 26. NAME OF COFFIN<br><u>None</u>               |  |  |  |
| 27. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 28. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 29. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 30. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 31. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 32. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 33. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 34. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 35. NAME OF CASK<br><u>None</u>                 |  |  |  |
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| 37. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 38. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 39. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 40. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 41. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 42. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 43. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 44. NAME OF CASK<br><u>None</u>                 |  |  |  |
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| 46. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 47. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 48. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 49. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 50. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 51. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 52. NAME OF CASK<br><u>None</u>                 |  |  |  |
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| 54. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 55. NAME OF CASK<br><u>None</u>                 |  |  |  |
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| 70. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 71. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 72. NAME OF CASK<br><u>None</u>                 |  |  |  |
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| 79. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 80. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 81. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 82. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 83. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 84. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 85. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 86. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 87. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 88. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 89. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 90. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 91. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 92. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 93. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 94. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 95. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 96. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 97. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 98. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 99. NAME OF CASK<br><u>None</u>                 |  |  |  |
| 100. NAME OF CASK<br><u>None</u>                |  |  |  |

1362

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                            |  |  |  |   |
|---|----------------------------|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>  |                            | c. LENGTH OF STAY IN 1b<br><b>Approx 13 months X KENSINGTON</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>MONTGOMERY</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>CARROLL HALL NURSING HOME</b>  |                            | d. STREET ADDRESS<br><b>3410 FARRAGUT STREET</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Grace</b> Middle <b>Wansley</b> Last <b>Jad.</b>  |                            | 4. DATE OF DEATH<br>Month <b>2</b> Day <b>9</b> Year <b>1960</b>   |  |  |   |
| 5. SEX <b>2</b>   | 6. COLOR OR RACE <b>Pw</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 4, 1881</b> | 9. AGE (In years last birthday)<br><b>78 yrs.</b>  | IF UNDER 1 YEAR<br>Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                            | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                            | 13. FATHER'S NAME<br><b>JOHN BOSERMAN</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>EMMALINE KITTLE</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                            | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | INFORMANT Address<br><b>Mrs. Lyle E. Mann, 3410 Farragut St. Kensington, Maryland</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocarditis, acute</b><br><b>522X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>(b) <b>Hypo-static Pneumonia</b> DUE TO<br>(c) <b>Arteriosclerosis general and cerebral</b> |                            |  |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c).<br><b>Arteriosclerosis general and cerebral</b>  |                            |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                            | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                            | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>5009 DEL RAY AVE, BETHESDA, MD</b>                                  |   |
| 20f. (City or town)<br><b>BETHESDA</b>  |                            | (County)<br><b>MD</b>  |  | (State)<br><b>MD</b>   |   |
| 21. I certify that I attended the deceased from <b>Oct. 21</b> , 1957, to <b>Jan. 2</b> , 1960, that I last saw the deceased alive on <b>Jan. 1</b> , 1960, and that death occurred at <b>1:02 P.M.</b> from the causes and on the date stated above.   |                            |  |  |  |   |
| ACTUAL SIGNATURE<br><b>Robert G. Angle</b>  |                            | DATE SIGNED<br><b>1/2/60</b>   |  |  |   |
| PHYSICIAN'S NAME (Type)<br><b>ROBERT G. ANGLE</b>   |                            |  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>TRANS. &amp; BURIAL 1/4/60</b>  |                            | 22b. DATE THEREOF<br><b>1/4/60</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>MAPLE GROVE CEMETERY</b>  |   |
| 22d. LOCATION (City, town, or county)<br><b>FAIRMONT, WEST VIRGINIA</b>   |                            | 22e. (State)<br><b>WEST VIRGINIA</b>   |  |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>WARNER E. PUMPHREY, INC.</b>   |                            | ADDRESS<br><b>SILVER SPRING, MD.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>JAN 4 '60</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Raymond A. Zucka</b>   |                            |  |  |  |   |

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C. 0

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SICIAN: The law requires that the death certificate be executed within 24 hours after death  
attending physician.  
Certificate has been signed by the attending physician and completely filled in by the funeral  
the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be fil

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00967

0975

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>COUNTY <b>Montgomery</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>57 Bethesda</b>  |  |
| c. LENGTH OF STAY IN 1b<br><b>1 year</b>  |                                  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>4858 Battery Lane</b>   |                                  | d. STREET ADDRESS<br><b>4858 Battery Lane</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Irene L. Waples</b>   |                                  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>17</b> Year <b>19 60</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 25, 1900</b>                 |
| 9. AGE (In years lost birthday) <b>59</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>22</b>   | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Ohio</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                  |   |  |
| 13. FATHER'S NAME<br><b>W. O. Harrington</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>William G. Waples-Son-Item #2</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis</b><br>DUE TO <b>170X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Adenocarcinoma of Breast.</b><br>DUE TO<br>(c) <b></b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 yrs</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 1960</b> to <b>1-17</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>1-14</b> 19 <b>60</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><b>W. T. Joyce</b>  |                                  | 22b. DATE<br><b>January 17, 1960</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>W. T. Joyce</b>   |                                  | 22d. ADDRESS<br><b>8106 Maple Ridge Rd., Bethesda, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>1-19-60</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Rockville, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 20 '60</b>   |  |
|   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Knaus</b>  |  |

MEDICAL CERTIFICATION

al, cremation, or removal, within 72 hours after death.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH  
DEATH CERTIFICATE

Montgomery

Married

Montgomery

Married

1 year

Married

825 Battery Lane

825 Battery Lane

Issue

Married

Jan. 20, 1900

Female

June 22, 1900

Age 32

Married

Married

Ohio

W. T. Love

Unknown

None

William G. Love - son - 12

W. T. Love

6104 Maple Ridge St.,

Married 1-1-00

Robert A. Love, Bedford, Maryland



## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|  |                                      |  |  |
|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN 1b<br><b>62 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Georgia</b><br>b. COUNTY<br><b>Atlanta</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Atlanta</b><br>d. STREET ADDRESS<br><b>877 Parkway Drive, N.E.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>Jay</b><br>Middle<br><b>Arthur</b><br>Last<br><b>WARONKER</b>   |                                      | 4. DATE OF DEATH<br>Month<br><b>January</b><br>Day<br><b>6</b><br>Year<br><b>1960</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Caucasian</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>1-21-23</b>   |
| 9. AGE (In years lost birthday)<br><b>36</b> yrs.  |                                      | 10. IF UNDER 1 YEAR<br>Months<br><b>36</b>   | 11. IF UNDER 24 HRS.<br>Days<br><b>36</b><br>Hours<br><b>36</b><br>Min.<br><b>36</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Insurance Agent</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>   |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Milton WARONKER</b>  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Rebecca RIVES</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |                                      | 16. SOCIAL SECURITY NO.<br><b>WWII</b>   |  |
| 17. INFORMANT<br><b>Hospital Records</b>   |                                      | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Hepatic Failure</b><br>581.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of the Liver</b><br>DUE TO (c) <b>Hepatolenticular Degeneration (Wilson's Disease)</b><br>life time |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>32 hrs</b><br><b>104 mo.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                      |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>November 5</b> , 19 <b>59</b> , to <b>January 6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>January 6</b> , 19 <b>60</b> , and that death occurred at <b>1:50 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>1-6-60</b>           |                                      |  |  |
| ACTUAL SIGNATURE <b>John Wood Davis</b>  |                                      | M.D. <b>U. S. Naval Hospital</b>   |  |
| PHYSICIAN'S NAME (Type) <b>John Wood DAVIS, LT, MC, USN</b>  |                                      | <b>Bethesda 14, Maryland</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial-Shipment 1-7-60</b>   |                                      | 22b. DATE THEREOF  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Atlanta</b>   |                                      | 22d. LOCATION (City, town, or county) (State)<br><b>Georgia</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>R. M. W. Chambers</b> ADDRESS <b>Washington, DC</b>  |                                      | 24a. REC'D BY REGISTRAR  |  |
| <b>W.W. Chambers Funeral Home, 1400 Chapin St., NW</b>   |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Charles L. Hines</b>  |  |

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

COAST GUARD VESSEL

003

Georgia

Department

Atlanta

62 days

Boatswain (Rural)

U. S. Naval Hospital

671 Parkway Drive, N.E.

WATERMAN

Atlanta

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1-8-50

U. S. Naval Hospital

Boatswain, Maryland

John Wood Davis, MD, MC, USN

1-7-50

Washington, DC

W. W. Chambers, Principal, 1400 Capital Bldg., NW

Atlanta

Georgia

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0977

## CERTIFICATE OF DEATH

00969

Reg. Dist. No.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>     |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clney</u>   |  |   |  | c. LENGTH OF STAY IN 1b <u>10 DAYS</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monrovia</u> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>   |  |   |  | d. STREET ADDRESS <u>1</u>   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First <u>Blanche</u> Middle <u>E.</u> Last <u>Watkins</u>  |  |   |  | <b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>31</u> Year <u>1960</u>   |  |  |  |
| 5. SEX <u>F</u>   |  | 6. COLOR OR RACE <u>W</u>               |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>March 14-1879</u>  |  |
| 9. AGE (In years last birthday) <u>80</u> yrs.  |  | IF UNDER 1 YEAR Months _____ Days _____ |  | IF UNDER 24 HRS. Hours _____ Min. _____  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mont. Co. Ind.</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>USA</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME <u>John Osborne ETCHISON</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Virginia Penn</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>   |  |   |  | 16. SOCIAL SECURITY NO. <u>NONE</u>  |  | 17. INFORMANT <u>Hosp. Records</u> Address _____   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]  |  |   |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO <u>480x</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Influenza</u><br>DUE TO (c) _____                                       |  |   |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u><br><u>6 days</u>   |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Semility - Parkinsonism, Hypertension, Arteriosclerosis, Fractured Hip</u>   |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                           |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>1/31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/31</u> , 19 <u>60</u> , and that death occurred at <u>5:25 P</u> .M., from the causes and on the date stated above. |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>G. F. Meadors</u> M.D.  |  |   |  | ADDRESS (Street, city or town, state) <u>MAIN ST.</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>G. F. MEADORS, M.D.</u>  |  |   |  | DATE SIGNED <u>1/31/60</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>2-3-60</u>         |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Providence</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Kemptown, Md.</u>                               |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>  |  |   |  | 24a. REC'D BY REGISTRAR <u>FEB 4 '60</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Charles E. Flaves</u>  |  |

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MADE IN U.S.A.

STANDARD FORM NO. 100-10

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br><i>JOHN A. SMITH</i>          |  | 2. SEX<br><i>MALE</i>                              |  |
| 3. AGE<br><i>45</i>                                  |  | 4. RACE<br><i>WHITE</i>                            |  |
| 5. DATE OF DEATH<br><i>1965-10-15</i>                |  | 6. TIME OF DEATH<br><i>10:30 AM</i>                |  |
| 7. PLACE OF DEATH<br><i>HOME</i>                     |  | 8. CAUSE OF DEATH<br><i>HEART DISEASE</i>          |  |
| 9. DISEASE OR INJURY<br><i>MYOCARDIAL INFARCTION</i> |  | 10. MANNER OF DEATH<br><i>NATURAL</i>              |  |
| 11. SIGNATURE OF PHYSICIAN<br><i>DR. J. B. SMITH</i> |  | 12. SIGNATURE OF REGISTRAR<br><i>JOHN A. SMITH</i> |  |
| 13. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 14. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 15. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 16. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 17. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 18. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 19. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 20. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 21. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 22. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 23. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 24. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 25. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 26. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 27. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 28. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 29. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 30. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 31. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 32. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 33. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 34. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 35. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 36. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 37. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 38. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 39. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 40. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 41. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 42. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 43. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 44. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 45. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 46. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 47. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 48. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 49. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 50. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 51. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 52. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 53. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 54. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 55. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 56. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 57. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 58. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 59. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 60. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 61. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 62. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 63. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 64. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 65. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 66. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 67. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 68. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 69. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 70. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 71. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 72. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 73. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 74. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 75. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 76. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 77. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 78. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 79. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 80. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 81. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 82. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 83. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 84. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 85. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 86. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 87. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 88. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 89. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 90. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 91. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 92. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 93. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 94. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 95. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 96. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 97. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 98. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>   |  |
| 99. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>     |  | 100. SIGNATURE OF WITNESS<br><i>JOHN A. SMITH</i>  |  |

0847

## CERTIFICATE OF DEATH

00970

Reg. Dist. No.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Takoma Park</i>   |  | c. LENGTH OF STAY IN Ib<br><i>55 days</i>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Burtonsville</i>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>Washington Sanitarium + Hosp.</i>   |  |   |  | d. STREET ADDRESS   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Elizabeth</i> Middle <i>SUSAN</i> Last <i>Weakley</i>  |  |   |  | 4. DATE OF DEATH<br>Month <i>1</i> Day <i>19</i> Year <i>1960</i>   |  |   |  |
| 5. SEX<br><i>female</i>  |  | 6. COLOR OF RACE<br><i>white</i>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>10-25-83</i>   |  |
| 9. AGE (In years last birthday)<br><i>76</i> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.<br>Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>house wife</i>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>OWN HOME</i>  |  | 11. BIRTHPLACE (State or foreign country)<br><i>Virginia</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |
| 13. FATHER'S NAME<br><i>Benjamin Broyles</i>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Lucinda JENKINS</i>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>none</i>  |  | 16. SOCIAL SECURITY NO.<br><i>none</i>  |  | INFORMANT Address<br><i>Son Mr. Cecil E. Weakley, Burtonsville, Md.</i>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>420.0 Congestive Cardiac Failure</i><br>DUE TO (b) <i>Atherosclerotic Heart Disease</i><br>DUE TO (c) <i>Diabetes Mellitus</i><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i><br><i>? years</i>                               |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <i>19</i>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <i>Nov 25, 1959</i> to <i>Jan 19, 1960</i> that I last saw the deceased alive on <i>Jan 18, 1960</i> , and that death occurred at <i>7:25 PM</i> , from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Robert A. Hare</i>  |  | M.D.  |  | ADDRESS (Street, city or town, state)<br><i>Takoma Park, Md.</i>  |  | DATE SIGNED<br><i>1/19/60</i>   |  |
| PHYSICIAN'S NAME (Type)<br><i>Robert A. HARE M.D.</i>  |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   |  | 22b. DATE THEREOF<br><i>1/22/60</i>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><i>FT. LINCOLN CEMETERY</i>   |  | 22d. LOCATION (City, town, or county) (State)<br><i>PRINCE GEO. COUNTY, MARYLAND</i>              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Warner E. Pumphrey, Inc.</i>  |  |   |  | ADDRESS<br><i>SILVER SPRING, MD.</i>  |  | 24a. REC'D BY REGISTRAR<br>DATE <i>JAN 20 '60</i>   |  |
|  |  |   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur L. Frank</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Washington, D.C. 20540

James Earl Ray

1000 14th Street, N.W.

Washington, D.C. 20004

John H. Hill, Jr., Secretary

U.S. Department of Justice

Washington, D.C. 20535

Attention: Mr. Hill

Enclosed for Mr. Hill

are two copies of

a letterhead memorandum

dated and captioned as above.

Very truly yours,

W. J. French

Special Agent in Charge

U.S. Department of Justice

Washington, D.C. 20535



0978

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

|  |                                      |   |                                    |   |                                      |   |   |
|--|--------------------------------------|---|------------------------------------|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                      |   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> <b>COUNTY</b> <b>Montgomery</b> |                                      |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>  |                                      |   |                                    | c. LENGTH OF STAY IN 1b<br><b>17 days</b>   |                                      |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Naval Hospital</b>  |                                      |   |                                    | e. STREET ADDRESS<br><b>1124 Parrish Drive</b>  |                                      |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Susan</b> Middle <b>Marie</b> Last <b>WEISS</b>  |                                      |   |                                    | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>6</b> Year <b>1960</b>  |                                      |   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Caucasian</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-9-58</b> | 9. AGE (In years last birthday)<br><b>1</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours | IF UNDER 24 HRS.<br>Hours Min.  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>George W. Weiss</b>  |                                      |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Colleen Enaley</b>   |                                      |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                      | 16. SOCIAL SECURITY NO.<br><b>None</b>  |                                    | INFORMANT<br><b>Hospital Records</b>  |                                      | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia + atelectasis</b><br><b>744.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Asystolia congenita</b> DUE TO<br>(c) <b>Suspected at 3 mos. Diagnosed at 8 mos.</b> |                                      |   |                                    |   |                                      |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                      |   |                                    |   |                                      |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    | 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                      | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)  |                                    |   |                                      |   |   |
| 21. I certify that I attended the deceased from <b>December 21, 1959</b> , to <b>January 6, 1960</b> , that I last saw the deceased alive on <b>January 6, 1960</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above.  |                                      |   |                                    |   |                                      |   |   |
| ACTUAL SIGNATURE <b>H. L. Walton</b>   |                                      |   |                                    | ADDRESS (Street, city or town, state)<br><b>U. S. Naval Hospital</b>  |                                      | DATE SIGNED<br><b>1-7-60</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>H. L. WALTON, LT, MC, USN</b>  |                                      |   |                                    | <b>Bethesda 14, Md.</b>   |                                      |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                      | 22b. DATE THEREOF<br><b>1-11-60</b>   |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |                                      | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington Virginia</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R.A. Pumphrey</b><br><b>R.A. Pumphrey Funeral Home, Bethesda, Md.</b>   |                                      |   |                                    | 24a. REC'D BY REGISTRAR<br><b>JAN 11 1960</b><br>DATE   |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Pumphrey</b>   |   |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Montgomery, Maryland, Rockville

Rebecca (Rural)

17 days

U. S. Naval Hospital

14th Portland Drive

George W. Nelson

Wills

January

Female

12-9-58

None

Montgomery

George W. Nelson

Colleen

None

None

Medical Records

December 21

January 6

0:30P

U. S. Naval Hospital

1-7-60

H. L. WATSON, JR, MC, USA

Rebecca R, MD.

1-11-60

Arlington National

Arlington

Virginia

U.S. Naval Hospital, Bethesda, Md.

## CERTIFICATE OF DEATH

00972

Reg. Dist. No.

|  |                               |  |                                  |
|--|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>0979</b> <b>MARYLAND</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>            |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>   |                               | c. LENGTH OF STAY IN lb <b>42 MINS</b>   |                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>  |                               | d. STREET ADDRESS <b>3508 FARTHING DRIVE</b>   |                                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>INFANT</b> Middle <b>BOY</b> Last <b>WERMTER</b>   |                               | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>28</b> Year <b>1960</b>  |                                  |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>1-27-'60</b> |
| 9. AGE (In years last birthday) yrs. <b>4.2 Mins</b>   |                               | IF UNDER 1 YEAR Months Days Hours Min.   |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                  |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                  |
| 13. FATHER'S NAME <b>RAYMOND WERMTER</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Adelaide BLAKE</b>   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                               | 16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>RAYMOND WERMTER - FATHER - SAME</b>  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypoxia</b><br>770.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Thyroiditis Fetalis of Metabolic Disturbance of Neonate</b><br>DUE TO (c) <b>Rh incompatibility (Anti C + Anti D antibodies)</b> |                               | INTERVAL BETWEEN ONSET AND DEATH <b>Approx 10</b>  |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <b>Michael L Buckley</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Michael L. Buckley, M.D.</b>                  |                               |  |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>1/29/60</b>   |                                  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Arlington</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>   |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Timothy Haulon</b> ADDRESS <b>-3831 Ga Ave NW</b>  |                               | 24a. REC'D BY REGISTRAR DATE <b>FEB 3 '60</b>  |                                  |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>  |                               |  |                                  |

1

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074303XV4

CERTIFICATE OF DEATH

1932



0852

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>58 Cherry Chase</i>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4914 Cumberland Ave</i>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) First <i>Mabelle</i> Middle <i>Alice</i> Last <i>West</i>   |  | 4. DATE OF DEATH Month <i>Jan.</i> Day <i>11</i> Year <i>1960</i>  |   |
| 5. SEX <i>Female</i>  | 6. COLOR OR RACE <i>White</i>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>April 26, 1876</i>                                  |
| 9. AGE (In years (day birthday) yrs. <i>83</i> )  |  | IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>   | IF UNDER 24 HRS. Months <i></i> Days <i></i> Hours <i></i> Min. <i></i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <i>N.Y.</i>  | 11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>                 |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |  | 13. FATHER'S NAME <i>Richard E. Turner</i>   |   |
| 14. MOTHER'S MAIDEN NAME <i>Mary E. Jennings</i>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)                                      |   |
| 16. SOCIAL SECURITY NO. <i>M. J. West</i>   |  | 17. INFORMANT Address <i>4914 Cumberland Ave Cherry Chase Md</i>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma Bladder</i><br>181.0<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i><br>DUE TO (c) <i></i>  |  |  | INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <i>19</i>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                    |
| 21. I certify that I attended the deceased from <i>March, 1959</i> , to <i>Jan 11, 1960</i> , that I last saw the deceased alive on <i>Jan 11</i> , 19 <i>60</i> , and that death occurred at <i>9:50 P.M.</i> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <i>2828 Conn Ave, N.W., DC</i> DATE SIGNED <i>1/11/60</i> |  |  |   |
| ACTUAL SIGNATURE <i>Armand B. Gordon</i>  |  | M.D. <i>2828 Conn Ave, N.W., DC</i>  |   |
| PHYSICIAN'S NAME (Type) <i>Armand B. Gordon, M.D.</i>   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>  | 22b. DATE THEREOF <i>1/12/60</i>   | 22c. NAME OF CEMETERY OR CREMATORY <i>Fairview Cemetery</i>  | 22d. LOCATION (City, town, or county) (State) <i>Blackensburg Rd Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Cherry Chase Funeral Home</i> ADDRESS <i>5193 7th Ave SE Wash DC</i>  |  | 24a. REC'D BY REGISTRAR <i>DATE JAN 14 '60</i>   | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>                       |

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0883

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>[REDACTED]        |  | 2. PLACE OF BIRTH<br>[REDACTED]        |  |
| 3. DATE OF BIRTH<br>[REDACTED]           |  | 4. SEX<br>[REDACTED]                   |  |
| 5. RACE<br>[REDACTED]                    |  | 6. OCCUPATION<br>[REDACTED]            |  |
| 7. MARITAL STATUS<br>[REDACTED]          |  | 8. CAUSE OF DEATH<br>[REDACTED]        |  |
| 9. PLACE OF DEATH<br>[REDACTED]          |  | 10. DATE OF DEATH<br>[REDACTED]        |  |
| 11. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 12. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 13. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 14. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 15. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 16. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 17. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 18. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 19. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 20. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 21. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 22. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 23. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 24. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 25. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 26. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 27. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 28. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 29. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 30. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 31. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 32. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 33. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 34. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 35. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 36. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 37. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 38. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 39. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 40. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 41. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 42. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 43. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 44. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 45. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 46. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 47. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 48. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 49. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 50. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 51. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 52. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 53. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 54. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 55. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 56. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 57. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 58. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 59. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 60. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 61. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 62. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 63. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 64. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 65. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 66. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 67. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 68. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 69. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 70. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 71. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 72. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 73. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 74. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 75. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 76. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 77. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 78. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 79. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 80. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 81. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 82. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 83. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 84. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 85. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 86. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 87. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 88. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 89. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 90. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 91. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 92. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 93. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 94. SIGNATURE OF NOTARY<br>[REDACTED]  |  |
| 95. SIGNATURE OF DECEASED<br>[REDACTED]  |  | 96. SIGNATURE OF WITNESS<br>[REDACTED] |  |
| 97. SIGNATURE OF PHYSICIAN<br>[REDACTED] |  | 98. SIGNATURE OF CLERK<br>[REDACTED]   |  |
| 99. SIGNATURE OF JUDGE<br>[REDACTED]     |  | 100. SIGNATURE OF NOTARY<br>[REDACTED] |  |

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE ACCURACY OF THIS RECORD. ANY CHANGES OR CORRECTIONS MUST BE MADE BY THE DEPARTMENT OF HEALTH. THIS CERTIFICATE IS VALID FOR ALL PURPOSES. IT IS THE DUTY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE ACCURACY OF THIS RECORD. ANY CHANGES OR CORRECTIONS MUST BE MADE BY THE DEPARTMENT OF HEALTH. THIS CERTIFICATE IS VALID FOR ALL PURPOSES.



## 0873 CERTIFICATE OF DEATH

Reg. Dist. No.

00974

|   |                                      |   |   |
|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |                                      | c. LENGTH OF STAY IN 1b<br><b>X Kensington</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>4001 Dresden Street</b>  |                                      | /d. STREET ADDRESS<br><b>4001 Dresden Street</b>  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Clara</b> Middle <b>T.</b> Last <b>WHALEY</b>   |                                      | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>6</b> Year <b>1960</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 29, 1862</b>  |
| 9. AGE (In years last birthday)<br><b>97</b> yrs.   |                                      | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>7</b> Hours <b></b> Min. <b></b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Wakefield, Rhode Island</b>   |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Charles Tucker</b>  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Mary Hall</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                      | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| INFORMANT<br><b>Mrs. Hope Eagle-Same Item #2</b>  |                                      | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last.<br>(b) <b>A'SCLEROTIC HEART DISEASE</b> DUE TO<br>(c) <b></b>                                       |                                      |   |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>4 HOURS</b><br><b>20 YRS.</b>  |                                      |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                      | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/>                                  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                      | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>AUG.</b> , 19 <b>55</b> , to <b>JAN 6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>JAN 6</b> , 19 <b>60</b> , and that death occurred at <b>4:35P</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>1150 CONN. AVE WASHINGTON 6, D.C.</b> DATE SIGNED <b>JAN 6, 1960</b> |                                      |   |   |
| ACTUAL SIGNATURE <b>Bertle Nelson</b>   |                                      | M.D. <b>1150 CONN. AVE WASHINGTON 6, D.C.</b>   |   |
| PHYSICIAN'S NAME (Type) <b>BERTLE NELSON</b>  |                                      | <b>WASHINGTON 6, D.C.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Bur-transit</b>   | 22b. DATE THEREOF<br><b>1/7/1960</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Wakefield</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington Co. Rhode Island</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey-Bethesda, Maryland</b>  |                                      | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 '60</b>   |   |
| ADDRESS   |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>   |   |

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1923

Montgomery

Montgomery

Montgomery

Montgomery

Montgomery

4001 Broadway Street

4001 Broadway Street

WHILEY

Class

Nov. 20, 1923

White

Montgomery, Rhode Island, USA

Montgomery

Mary Hall

Charles Foster

Montgomery, Rhode Island, USA

White

ACUTE HEART DISEASE

ACUTE HEART DISEASE

Jan 6 1924

Jan 6 1924

BETIE NELSON

1120 Conn Ave  
WASHINGTON D.C.

Robert A. Murphy-Boston, Maryland

Washington Co. Rhode Island

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG255 2-4-60 et  
0879 CERTIFICATE OF DEATH

Reg. Dist. No. 00975

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MD.</b> b. COUNTY <b>Pr. Geo.</b> ✓                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CITEVERLY</b> 1642-2   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS</b>   |                                  | d. STREET ADDRESS <b>5800 DEWEY ST</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>AARON</b> Middle <b>WHITE</b> Last <b>WHITE</b>  |                                  | 4. DATE OF DEATH<br>Month <b>JAN</b> Day <b>29</b> Year <b>1960</b>  |  |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>W</b>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>3-15-75</b> 48 yrs.  |
| 9. AGE (In years last birthday) <b>48</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  | IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <b>PA.</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>PA.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>SOLOMON WHITE</b>   |                                  | 14. MOTHER'S MAIDEN NAME <b>Minnie Goldberg</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>   |                                  | 16. SOCIAL SECURITY NO. <b>MR. S. PASEKOFF</b> Address <b>Above</b>  |  |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b><br><b>145.0</b><br>DUE TO (b) <b>Metastatic carcinoma 9 Rt. Tonsil.</b><br>DUE TO (c) <b>years</b>               |                                  | INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |
| 18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  | 20b. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |
| 20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |                                  | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20e. (City or town)  |                                  | 20f. (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>JAN 1-27-60</b> , 19 <b>60</b> , to <b>1-29-60</b> , 19 <b>60</b> that I last saw the deceased alive on <b>1-27-60</b> , 19 <b>60</b> , and that death occurred at <b>8:25</b> M, from the causes and on the date stated above. |                                  |  |  |
| ACTUAL SIGNATURE <b>JEROME A. EPSTEIN</b> M.D.   |                                  | DATE SIGNED <b>1-29-60</b>   |  |
| PHYSICIAN'S NAME (Type) <b>JEROME A. EPSTEIN, MD</b>   |                                  | ADDRESS (Street, city or town, state) <b>2025 Eye St, NW, Wash DC</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 22b. DATE THEREOF <b>1-31-60</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Friendship</b>  | 22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lwin</b> ADDRESS <b>2100 Eutan Place</b>  |                                  | 24a. REC'D BY REGISTRAR <b>1</b> '60   |  |
| 24b. REGISTRAR'S SIGNATURE <b>Charles E. Hines</b>   |                                  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*[Faint, illegible text throughout the form, likely bleed-through from the reverse side. Discernible fragments include:]*

NAME OF DECEASED: \_\_\_\_\_

AGE: \_\_\_\_\_

SEX: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

Cause of Death: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

Signature of Registrar: \_\_\_\_\_

0980

CERTIFICATE OF DEATH

Reg. Dist. No.

00976

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 BETHESDA</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>  |  | d. STREET ADDRESS <u>17508 CLAKENDON Rd.</u>   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Julian</u> Middle <u>WYTH</u> Last <u>Whiting</u>   |  | 4. DATE OF DEATH Month <u>1</u> Day <u>23</u> Year <u>1960</u>   |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 9, 1885</u>                                     |
| 9. AGE (In years lost birthday) <u>74</u> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min.   | IF UNDER 24 HRS. Months Days Hours Min.                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>LAWYER</u>  | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>                |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |  |  |
| 13. FATHER'S NAME <u>WM. KENNON WHITING</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Kate VEIRS</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |  | 16. SOCIAL SECURITY NO. <u>-</u>   |  |
| INFORMANT Address <u>MARGARET S. (WIFE) SAME</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary artery occlusion.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease.</u> DUE TO<br>(c) <u>?</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>                         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                     |
| 21. I certify that I attended the deceased from <u>Jan. 23, 1960</u> to <u>Jan. 23, 1960</u> , that I last saw the deceased alive on <u>Jan. 23, 1960</u> , and that death occurred at <u>5:35 P.M.</u> from the causes and on the date stated above.  |  |  |  |
| ACTUAL SIGNATURE <u>George A. Gray, Jr.</u> M.D.   |  | ADDRESS (Street, city or town, state) <u>4422 East-West Hwy, Bethesda 14, Maryland</u>   |  |
| PHYSICIAN'S NAME (Type) <u>George A. GRAY, JR. M.D.</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>1/26/60</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>   | 22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>   |  | 24a. REC'D BY REGISTRAR <u>JAN 26 '60</u>  | 24b. REGISTRAR'S SIGNATURE <u>Carlton S. Thompson</u>                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

00977

0981

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>c. STATE <b>District of Columbia</b> <b>DISTRICT OF COLUMBIA</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b> <b>47X-3</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Suburban Hospital</b>   |   | d. STREET ADDRESS<br><b>3624 Brandywine St., N.W.</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WILLIAM</b> Middle <b>H.</b> Last <b>WHITTLESEY</b>  |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>5</b> Year <b>19 60</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/18/1891</b>  |
| 9. AGE (In years last birthday)<br><b>68</b> yrs.  |   | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>17</b>   | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Pharmacist</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Drugs</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>                       |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 13. FATHER'S NAME<br><b>William Henry Whittlesey</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary Mae Richards</b>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |  |
| 16. SOCIAL SECURITY NO.<br><b>1917 - 18</b>  |   | 17. INFORMANT<br><b>William H. Whittlesey Jr.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.<br>(b) <b>Hypertensive Cardiovascular Disease</b><br>(c) <b></b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>20 hrs</b><br><b>several years</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m. <b></b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>1/4</b> , 19 <b>60</b> , to <b>1/5</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/4</b> , 19 <b>60</b> , and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above.   |   |   |  |
| ACTUAL SIGNATURE<br><b>Michel M. Healy</b>   |   | ADDRESS (Street, city or town, state)<br><b>Washington Clinic Wash DC</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>Michel M. Healy</b>  |   | DATE SIGNED<br><b>1/5/60</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>1-8-60</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Prince George Co., Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>  |   | 24a. REC'D BY REGISTRAR<br><b>JAN 7 '60</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Carlton S. Hines</b>                          |

1

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

0001

Department of Health

Washington

Suburban Hospital

ELLAN, B. WHITE

Age

1 Year

Sex

Male

1000-1000-1000

1000-1000-1000

1000-1000-1000

1000-1000-1000

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <i>Montgomery</i> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>Md.</i> b. COUNTY <i>MONTGOMERY</i>      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>   |  | c. LENGTH OF STAY IN 1b <i>17 days</i>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium &amp; Hospital</i>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) First <i>May</i> Middle <i>Esther</i> Last <i>Wilkinson</i>   |  | 4. DATE OF DEATH Month <i>1</i> - Day <i>1</i> Year <i>1960</i>   |  |
| 5. SEX <i>Female</i>  | 6. COLOR OR RACE <i>White</i>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>6-30-82-77</i>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>   | 11. BIRTHPLACE (State or foreign country) <i>D. C.</i>                         |
| 13. FATHER'S NAME <i>Daniel B. Imnich</i>   |  | 14. MOTHER'S MAIDEN NAME <i>Augusta Hanlein</i>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <i>none</i>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Generalized arteriosclerosis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ DUE TO _____<br>(c) _____ |  | INTERVAL BETWEEN ONSET AND DEATH <i>years</i>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <i>Dec. 31, 1959</i> to <i>Jan 1, 1960</i> , that I last saw the deceased alive on <i>Dec. 31, 1959</i> , and that death occurred at <i>9:45 AM</i> , from the causes and on the date stated above.   |  |   |  |
| ACTUAL SIGNATURE <i>Abraham W. Danish</i> M.D.  |  | ADDRESS (Street, city or town, state) <i>927 Pershing Dr Silver Spring, Md</i> DATE SIGNED <i>1-1-60</i>                                      |  |
| PHYSICIAN'S NAME (Type) <i>ABRAHAM W. DANISH</i>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>   | 22b. DATE THEREOF <i>1/4/60</i>  | 22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>  | 22d. LOCATION (City, town, or county) (State) <i>Prince George County, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i> ADDRESS <i>SILVER SPRING, MD.</i>  |  | 24a. REC'D BY REGISTRAR <i>JAN 5 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Travis</i>   |  |

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
ISM 9/58

CERTIFICATE OF DEATH

1920



0982 CERTIFICATE OF DEATH

00979

Reg. Dist. No.

|   |                                     |  |  |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Colorado</b> b. COUNTY <b>El Paso</b> ✓             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Colorado Springs</b> <b>44X-3</b>                                 |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>9208 Seven Locks Road</b>  |                                     | d. STREET ADDRESS<br><b>44X-3</b>  |  |
| 3. NAME OF DECEASED (Type or print) <b>FLORENCE SARAH WILL</b> First Middle Last  |                                     | 4. DATE OF DEATH <b>January 23,</b> 19 <b>60</b> Month Day Year  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/30/187</b>  |
| 9. AGE (In years last birthday) <b>72</b> yrs.  |                                     | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Kansas</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Henry Keeling</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Ida Barlow</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |                                     | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Dr. Otto A. Will, Jr. - Item # 1</b>  |                                     | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism bilateral</b><br><b>199.2</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.<br>(b) <b>Adno Carcinoma with wide spread metastasis</b> DUE TO<br>(c) _____ |                                     | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                     | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                     | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Dec 20</b> , 19 <b>59</b> , to <b>Jan 23</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 23</b> , 19 <b>60</b> , and that death occurred at <b>6:15 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>104 S Washington St Rockville, Md</b> DATE SIGNED     |                                     |  |  |
| ACTUAL SIGNATURE <b>Corrine Cooper</b> M.D. <b>104 S Washington St</b>  |                                     | PHYSICIAN'S NAME (Type) <b>Corrine Cooper</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   | 22b. DATE THEREOF<br><b>1/25/60</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Prince George Co., Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Tyson Wheeler Funeral Home</b><br><b>1331 E. Montg. Ave., Rockville, Md.</b>   |                                     | 24a. REC'D BY REGISTRAR<br><b>JAN 25 '60</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. K...</b>   |                                     |  |  |

TO HOSPITAL OR TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

CERTIFICATE OF DEATH



DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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Reg. Dist. No.

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|--|--------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring's Md</b>  |                                | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Springs, Md</b>                                 |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Own home</b>  |                                |   |   | d. STREET ADDRESS<br><b>2200 Michigan Ave,</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Nellie</b> Middle <b>Virginia</b> Last <b>Williams</b>   |                                |   |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>18</b> Year <b>1960</b>   |   |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Col</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb 17, 1888</b> |   | 9. AGE (In years last birthday)<br><b>71</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Henry Stewart</b>  |                                |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Louise Johnson</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                | 16. SOCIAL SECURITY NO.<br><b>No</b>  |   | INFORMANT<br><b>Mrs Ellouise Crockett</b>   |   | Address<br><b>same Item #2</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>352x Congestive Heart Failure</b><br>DUE TO (b) <b>old age</b><br>DUE TO (c) <b>Paralysis</b>  |                                |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mo.</b>                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>None</b>   |                                |   |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>— 19</b>   |                                | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)<br><b>Silver Spring Mont. Md</b>                             |  |
| 21. I certify that I attended the deceased from <b>Jan 15</b> , 19 <b>60</b> , to <b>Jan 17</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 15</b> , 19 <b>60</b> , and that death occurred at <b>11:45</b> P.M. from the causes and on the date stated above. |                                |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br><b>Frank G. Leslie</b>   |                                | M.D.  |   | ADDRESS (Street, city or town, state)<br><b>8901 Ga. av. Silver Spring Md</b>   |   | DATE SIGNED<br><b>Jan 19. 60.</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>Frank G. Leslie</b>  |                                |   |   |   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                | 22b. DATE THEREOF<br><b>1/22/60</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ash Memorial Cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Sandy Springs Md</b>                          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert L. Snowden</b>   |                                | ADDRESS<br><b>Rockville, Md</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 25 '60</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Knapp</b>  |  |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00981**

|   |  |   |  |  |  |   |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u><br>c. LENGTH OF STAY IN 1b <u>2 wks</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>717 Marshall Ave</u>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maine</u> b. COUNTY <u>Androscoggin</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Auburn</u> <u>57X-3</u><br>d. STREET ADDRESS <u>105 Yarnage Ave</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Claude</u> Middle <u>Douglas</u> Last <u>Wing</u>  |  |   |  | <b>4. DATE OF DEATH</b><br>Month <u>Jan</u> Day <u>2</u> Year <u>1960</u>  |  |   |  |   |  |   |  |
| <b>5. SEX</b><br><u>male</u>  |  | <b>6. COLOR OR RACE</b><br><u>white</u> |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><u>Sept 19 1912</u>                                |  | <b>9. AGE</b> (In years last birthday) <u>57</u> yrs. |  | <b>IF UNDER 1 YEAR</b><br>Months <u>2</u> Days <u>2</u> Hours <u>19</u> Min.              |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>owner</u>  |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Transportation Co.</u>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Canada</u>             |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |  |   |  |
| <b>13. FATHER'S NAME</b><br><u>James Wing</u>   |  |   |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Floella Whittier</u>                    |  |   |  |   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)<br><u>No</u>  |  |   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>Unknown</u>   |  | <b>17. INFORMANT</b><br><u>Fern Reid (daughter)</u>                           |  |   |  | Address <u>Item 1</u>   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>   |  |   |  |  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |   |  |   |  |   |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>  |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>19</u> a. m. p. m.   |  |   |  | <b>20d. INJURY OCCURRED</b><br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) |  | <b>20f. (City or town)</b>                            |  | (County) (State)  |  |
| <b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> |  |   |  |  |  |   |  |   |  |   |  |
| <b>ACTUAL SIGNATURE</b> <u>Frank J. Broschant</u> <b>M.D.</b>   |  |   |  |  |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>                        |  |   |  |   |  |
| <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschant</u>   |  |   |  |  |  | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>                    |  |   |  |   |  |
| <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>  |  |   |  |  |  | <b>DATE SIGNED</b> <u>Jan 2 - 60</u>  |  |   |  |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial-transit 1-3-60</u>  |  |   |  | <b>22b. DATE THEREOF</b>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Mt. Auburn Cemetery</u>       |  |   |  | <b>22d. LOCATION</b> (City, town, or county) (State)<br><u>Androscoggin County, Maine</u> |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>ROBERT A. PUMPHREY</u>  |  |   |  |  |  | <b>ADDRESS</b><br><u>Bethesda, Md.</u>  |  |   |  |   |  |
| <b>24a. REC'D BY REGISTRAR</b>  |  |   |  |  |  | <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Jan 5 '60</u>                         |  |   |  |   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise.

Key sections and fields include:

- Patient Information:** Name, Address, Age, Sex, Race, Religion, Occupation, Education, Marital Status, Date of Birth, Date of Death.
- Medical History:** Present Illness, Past Illnesses, Allergies, Medications, Family History, Social History (Smoking, Alcohol, Drug Use).
- Examination Findings:** General Appearance, Vital Signs, Physical Examination (Head, Neck, Chest, Abdomen, Extremities, Genitalia), Laboratory Tests, Imaging Studies.
- Diagnosis:** Primary and Secondary Diagnoses.
- Disposition:** Place of Death, Cause of Death, Manner of Death.
- Signature and Certification:** Signature of Medical Examiner, Date, and Seal.

## CERTIFICATE OF DEATH

00982

Reg. Dist. No.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>MONTGOMERY</u> MARYLAND   |  | 2. USUAL RESIDENCE Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GERMANTOWN</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARYLANDERS NURSING HOME</u>  |  | d. STREET ADDRESS <u>None</u>  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |
| 3. NAME OF DECEASED (Type or print) <u>Matie E Winnie</u>   |  | 4. DATE OF DEATH <u>JAN 9</u> Month <u>9</u> Day <u>19</u> Year <u>1960</u>  |   |
| 5. SEX <u>FEMALE</u>  | 6. COLOR OR RACE <u>WHITE</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 1, 1881</u>                            |
| 9. AGE (In years last birthday) <u>78</u> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min.   | IF UNDER 24 HRS. Months Days Hours Min.                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H-Wife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>   | 11. BIRTHPLACE (State or foreign country) <u>Ohio</u>           |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |   |
| 13. FATHER'S NAME <u>George Henning</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Alice Leivy</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>Yes</u>   |   |
| 17. INFORMANT <u>E.R. Henning, Box 475 Route 1 Edgewood Md.</u>   |  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u><br>422.1<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO<br>(c) <u>10 years</u> |  | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                            |
| 21. I certify that I attended the deceased from <u>Nov. 18, 1958</u> to <u>Jan. 9, 1960</u> , that I last saw the deceased alive on <u>Jan. 7, 1960</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.   |  |  |   |
| ACTUAL SIGNATURE <u>James P. Kern</u> M.D.  |  | ADDRESS (Street, city or town, state) <u>Shadyside Md.</u>   |   |
| PHYSICIAN'S NAME (Type) <u>James P. Kern</u>  |  | DATE SIGNED  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>1/11/60</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>   | 22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>  |  | ADDRESS <u>1400 Chapin St. Wash. D.C.</u>  | 24a. REC'D BY REGISTRAR <u>DATE JAN 15 '60</u>                  |
|   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 0984 CERTIFICATE OF DEATH

Reg. Dist. No.

00983

|  |                               |  |                                       |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>North Carolina</b><br>b. COUNTY                     |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |                               | c. LENGTH OF STAY IN 1b <b>25 days</b>   |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Hallie</b> Middle <b>Edna</b> Last <b>Yarbrough</b>  |                               | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>31</b> Year <b>1960</b>  |                                       |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>June 22, 1907</b> |
| 9. AGE (In years lost birthday) <b>52</b> yrs.   |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>Textile Worker</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>   |                                       |
| 11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |                                       |
| 13. FATHER'S NAME <b>Doras Williams</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Ada Byers</b>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                               | 16. SOCIAL SECURITY NO. <b>214-26-4938</b>   |                                       |
| 17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>  |                               |  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma, spindle cell type, thyroid gland</b><br>DUE TO <b>194X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Obstruction; left main bronchus with atelectasis</b><br>DUE TO <b>2 days</b><br>(c) <b>Partial atelectasis right lung</b><br>DUE TO <b>days</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b><br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               |  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that I attended the deceased from <b>January 6, 1960</b> , to <b>January 31, 1960</b> that I last saw the deceased alive on <b>January 31, 1960</b> , and that death occurred at <b>10:15 A.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>2/1/60</b><br>ACTUAL SIGNATURE <b>Alan B. Retik</b> M.D. <b>The Clinical Center</b><br>PHYSICIAN'S NAME (Type) <b>ALAN B. RETIK</b> <b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>   |                               |  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral Home</b>  |                               | 22b. DATE THEREOF <b>2/1/60</b>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Pisgah Cemetery</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Lincoln Co. N. Carolina</b>   |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b> <b>Bethesda, Maryland</b>   |                               | 24a. REC'D BY REGISTRAR <b>FEB 4 '60</b>   |                                       |
|  |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>   |                                       |

1

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

UNITED STATES OF AMERICA

North Carolina

Washington

85 days

Postcard

Postcard

The Clinical Center, Bethesda, Md.

Washington

March

Health

22

June 22, 1907

Female

U. S. A.

North Carolina

Female

Female Worker

Age 30

Lower Middle

The Medical Record

22-25-1907 The Clinical Center, Bethesda, Md.

months

Cardiac, vitals all good, thyroid gland

General: Left main bronchus with stenosis 2 days

days

Partial stenosis, right lung

20

January 11

20

January 11

20

January 11

2/1/08

The Clinical Center

National Institute of Health

Bethesda, Md.

ALAN P. BELL

2/1/08

2/1/08

## CERTIFICATE OF DEATH

Reg. Dist. No.

00984

0985

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Montgomery</u> b. COUNTY <u>Montgomery</u> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  |  | c. LENGTH OF STAY IN 1b <u>30 min.</u>  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>P.</u> Last <u>Yoshioka</u>  |  |  | 4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1960</u>   |  |  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>Oriental</u>   |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <u>3/19/1899</u>  |  | 9. AGE (In years last birthday) <u>70</u> yrs.   |   | IF UNDER 1 YEAR Months <u>9</u> Days <u>18</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Assembler</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>   |   | 11. BIRTHPLACE (State or foreign country) <u>Japan</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |  | 13. FATHER'S NAME <u>Yoshioka</u>   |  |  |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  |  |
| 16. SOCIAL SECURITY NO. <u>579-44-1340</u>   |  |  | INFORMANT Address <u>Ruby Yoshioka, same as above</u>   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction</u><br>(c) <u>coronary artery disease</u> |  |  |   |  | INTERVAL BETWEEN ONSET OF DEATH <u>2 min.</u><br><u>6 hours</u>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>  |  |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town) (County) (State)   |  | 21. I certify that I attended the deceased from <u>Jan 5</u> , 19 <u>60</u> , to <u>Jan 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 5</u> , 19 <u>60</u> , and that death occurred at <u>6:20</u> M, from the causes and on the date stated above.<br>(also seen by Dr. Joseph Bailey on Jan 5 - patient's private doctor)<br>ACTUAL SIGNATURE <u>Edward W. Youngblood</u> M.D. ADDRESS (Street, city or town, state) <u>WASHINGTON CLINIC WASHINGTON 15, D.C.</u> DATE SIGNED <u>1/5/60</u> |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>   |  | 22b. DATE THEREOF <u>1-6-60</u>  |   | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>   |  |
| 22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>  |  | 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey, Bethesda, Maryland</u>   |   |  |  |
| 24a. REC'D BY REGISTRAR DATE <u>JAN 7 '60</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>  |   |  |  |

1

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

40004

CERTIFICATE OF DEATH

1921

LAST NAME, FIRST NAME, MIDDLE NAME, INITIALS

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

SIGNATURE OF MINISTER

SIGNATURE OF REGISTRAR

SIGNATURE OF CLERK

SIGNATURE OF JUDGE

SIGNATURE OF SHERIFF

SIGNATURE OF SHERIFF'S CLERK

SIGNATURE OF SHERIFF'S DEPUTY

SIGNATURE OF SHERIFF'S ASSISTANT

SIGNATURE OF SHERIFF'S CLERK

SIGNATURE OF SHERIFF'S DEPUTY

SIGNATURE OF SHERIFF'S ASSISTANT

SIGNATURE OF SHERIFF'S CLERK

SIGNATURE OF SHERIFF'S DEPUTY

SIGNATURE OF SHERIFF'S ASSISTANT

SIGNATURE OF SHERIFF'S CLERK

SIGNATURE OF SHERIFF'S DEPUTY

SIGNATURE OF SHERIFF'S ASSISTANT

## CERTIFICATE OF DEATH

Reg. Dist. No.

00985

0844

|   |                           |  |  |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montg.</i> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Md</i> b. COUNTY <i>Montg</i>                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park.</i>  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park.</i>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>075 Wash. San + Hosp -</i>  |                           | d. STREET ADDRESS <i>1806 Kennelholme</i>  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Elizabeth Zeidler</i>  |                           | 4. DATE OF DEATH Month Day Year <i>1-15-60</i>   |  |
| 5. SEX <i>F</i>   | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>12/8/75</i>  |
| 9. AGE (In years last birthday) <i>84</i> yrs.  |                           | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <i>Genl. &amp; DA.</i>   |  |
| 11. BIRTHPLACE (State or foreign country) <i>Pa</i>   |                           | 12. CITIZEN OF WHAT COUNTRY? <i>US</i>   |  |
| 13. FATHER'S NAME <i>William H Zeidler</i>  |                           | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Sleight</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>   |                           | 16. SOCIAL SECURITY NO. <i>Informant</i> Address <i>Sanatorium Records.</i>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>420.1 Hypertensive Pneumonia.</i><br>DUE TO (b) <i>Chronic Myocarditis.</i><br>DUE TO (c) <i>Coronary occlusion.</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Freq attacks of failure since</i> |                           |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>4 days</i><br><i>5 yrs.</i><br><i>9/28/58</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <i>4/11</i> , 19 <i>40</i> , to <i>1/15</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1/14</i> , 19 <i>60</i> , and that death occurred at <i>6 A</i> M. from the causes and on the date stated above.  |                           |  |  |
| ACTUAL SIGNATURE <i>Howard T. Morse</i> M.D.  |                           | ADDRESS (Street, city or town, state) DATE SIGNED <i>CARROLL AVE. TAK PR. MD 1/15/60</i>   |  |
| PHYSICIAN'S NAME (Type) <i>HOWARD T. MORSE</i>  |                           | <i>CARROLL AVE TAK PR. MD</i>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF         | 22c. NAME OF CEMETERY OR CREMATORY   | 22d. LOCATION (City, town, or county) (State)  |
| <i>Burial</i>   | <i>Jan 18, 1960</i>       | <i>George Washington Cemetery</i>  | <i>Prince Georges Co. MD</i>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>J. Arthur Walters 254 Carroll St NW</i>   |                           | REC'D BY REGISTRAR DATE <i>JAN 19 '60</i>  |  |
|   |                           | 24. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>   |  |

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

Blank certificate form with faint horizontal lines and a vertical margin line on the right side.

